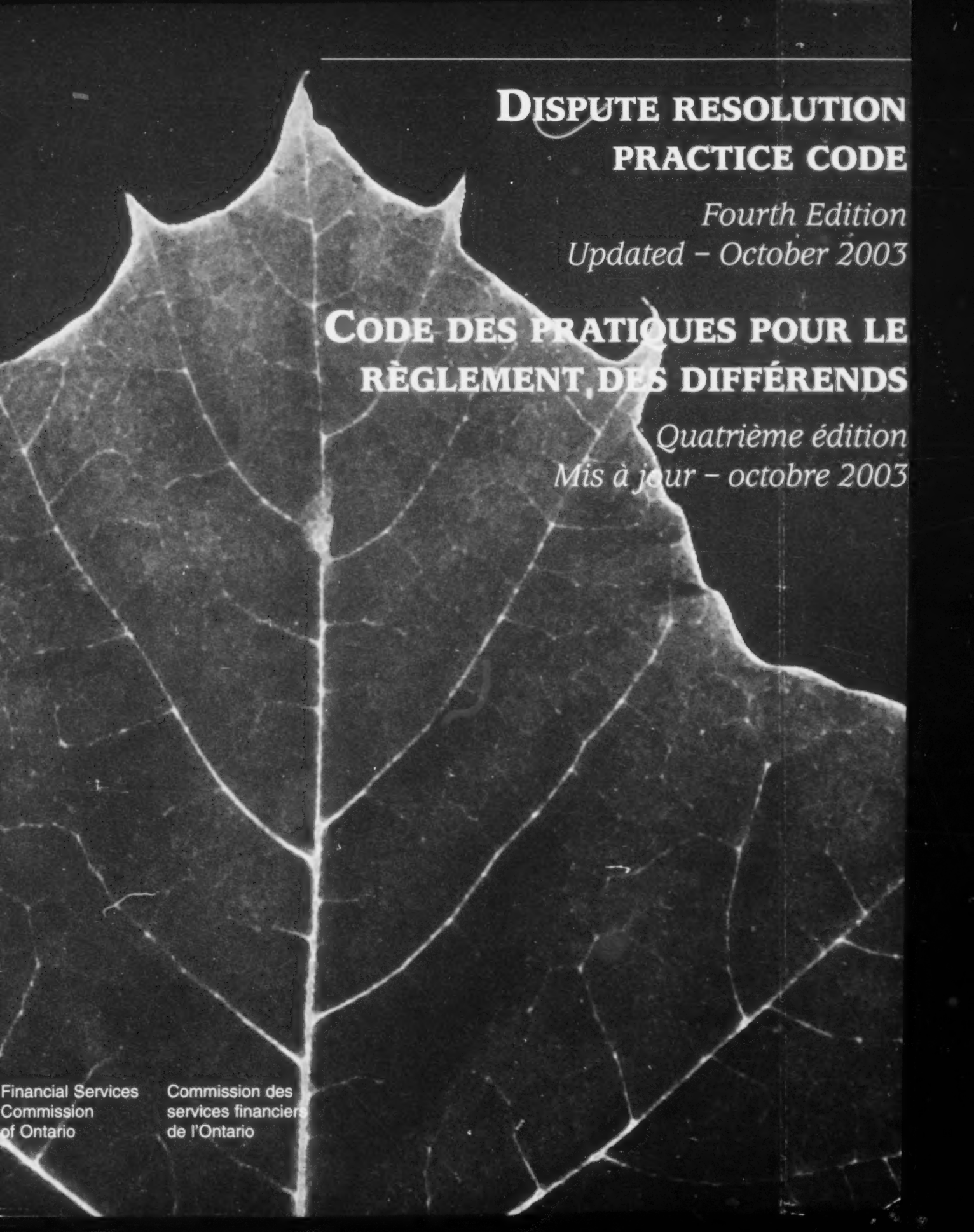

DISPUTE RESOLUTION PRACTICE CODE

Fourth Edition
Updated – October 2003

CODE DES PRATIQUES POUR LE RÈGLEMENT DES DIFFÉRENDS

Quatrième édition
Mis à jour – octobre 2003

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

104-02296/

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Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

October 2003

Dispute Resolution Practice Code (Fourth Edition) – 2003 Revisions

More than two years have passed since the introduction of the Fourth Edition of the Dispute Resolution Practice Code. We are pleased to provide a package of revisions that address certain housekeeping matters, as well as responding to recent amendments to the *Insurance Act* and regulations, including the *Statutory Accident Benefits Schedule – Accidents On or After November 1, 1996*.

To update your copy of the Practice Code, please insert the revisions according to the update schedule included in this package. Additional copies of the Practice Code and the 2003 revisions can be purchased from Publications Ontario, phone (416) 326-5300, or toll-free at 1-800-668-9938.

Please note that the Dispute Resolution Forms (Section G) have not been revised. However, some of the recent legislative changes will affect our practices. For example, the rules about attendance at insurer examinations (IEs) and Designated Assessment Centres (DAC) have been tightened. Under the new regulations, insured persons cannot commence mediation unless they have made themselves reasonably available for certain IEs. If they did not attend a scheduled IE, they will not be considered to have made themselves reasonably available unless they attend a rescheduled appointment for the examination. Similarly, insured persons who have not undergone a required DAC assessment cannot commence mediation.

There are also new rules about representatives. Effective November 1, 2003, non-lawyers cannot represent an insured person for compensation unless they:

- have met the Superintendent's filing requirements and have a SABS representative file number; or

- are employed by a law firm and are directly supervised by a lawyer.

In addition to this package of revisions, we anticipate making further changes in the near future. However, before doing so, we want to involve our staff and stakeholders in broader discussions aimed at making the dispute resolution process as responsible, fair and effective as possible.

Sincerely,

David Draper
Director of Arbitrations

Barbara Dudzinski
Director, Dispute Resolution Services

DISPUTE RESOLUTION PRACTICE CODE

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Financial Services Commission

General Inquiries
(416) 250-6714 (local)
(800) 517-2332 (toll free)

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The **Dispute Resolution Practice Code ("Code")** is a user's guide to resolving disputes between consumers and insurers involving statutory accident benefits claims under the *Insurance Act* and the *Statutory Accident Benefits Schedule ("SABS")*.

The **Code** is published by the Dispute Resolution Group of the **Financial Services Commission of Ontario** ("FSCO" or the "Commission"). Although there have been previous editions of the **Code**, this edition is the first published by the Dispute Resolution Group as part of FSCO.

FSCO is responsible for regulating the insurance sector as well as other financial service sectors in Ontario, namely, pensions, credit unions and caisses populaires, cooperatives, mortgage brokers and the loan and trust sectors. It is an arm's-length agency of the Ministry of Finance. FSCO provides regulatory and direct services that protect the public interest and enhance public confidence in the regulated sectors.

FSCO was established on July 1, 1998, under the *Financial Services Commission of Ontario Act, 1997*. It amalgamated the operations of the former Ontario Insurance Commission, the Pension Commission of Ontario and the Deposit Institutions Division of the Ministry of Finance.

The **Code** creates rules for timely, cost-effective and fair dispute resolution services provided through FSCO's Dispute Resolution Group. The rules of procedure in this **Code** apply to new applications as well as cases already in progress. The rules have been made after extensive consultations with users of the dispute resolution system.

THE SERVICES OF THE DISPUTE RESOLUTION GROUP

The Dispute Resolution Group at the Commission provides mediation, neutral evaluation and arbitration services. There is also a process for appealing arbitration orders on a question of law, and a process for varying or revoking orders.

If consumers and insurers are unable to resolve disputes about statutory accident benefits, the first step in the dispute resolution process is mediation. Mediation of such disputes is mandatory in Ontario and must be conducted through the Commission before the dispute can proceed to arbitration or court. The insured person is charged no fee for mediation. However, each party must pay for its own expenses, which may include lawyer's fees, travelling expenses, accounting services, and additional medical reports.

Mediation is an informal process in which a mediator helps parties involved in a dispute to clarify issues and find solutions that lead to a satisfactory outcome. The Mediation Unit of the Dispute Resolution Group has established a successful record in mediation, achieving full or partial success in over 75 percent of mediations. In December 1998, the Unit was awarded the prestigious Amethyst Award for outstanding achievement by the Ontario Public Service.

If the dispute remains unresolved after mediation at the Commission, the insured person has a number of choices. He or she can continue to negotiate directly with the insurance company. Alternatively, the insured person can opt for arbitration at

the Commission, private arbitration, private neutral evaluation or a court action. Each option has its own rules, and the insured person may not be able to switch from one system to another. For example, once an action has been commenced in court, the insured person may not be able to switch to arbitration at the Commission, or vice versa.

ABOUT THIS CODE

This **Code** will help the parties move through the Commission's dispute resolution process. It explains what is required of everyone involved and sets out rules for such matters as the filing of documents, time limits and payment of fees and expenses. Of particular importance are the rights and responsibilities of insurers and claimants when dealing with statutory accident benefits claims. These rights and responsibilities are outlined in **Guidelines B 2-1 and B 3-1**, which may be found in **Section B** of the **Code.**

It is important to note that the specific types of benefits, amounts, and eligibility requirements for benefits, will differ depending on when the motor vehicle accident took place.

If the accident occurred:	The applicable legislation is:
• on or after November 1, 1996	• *Insurance Act*, R.S.O. 1990, c.I.8, as amended, including amendments under the *Automobile Insurance Rate Stability Act*, 1996 [AIRSA], also known as **Bill 59**; and • *Statutory Accident Benefits Schedule – Accidents On or After November 1, 1996*, Ontario Regulation 423/96, as amended [referred to generally as *SABS*]. • Note: the legislation was substantially amended, effective October 1, 2003.
• on or between January 1, 1994 and October 31, 1996	• *Insurance Act*, R.S.O. 1990, c.I.8, as amended by the *Insurance Statute Law Amendment Act*, 1993, also known as **Bill 164**; and • *Statutory Accident Benefits Schedule – Accidents After December 31, 1993 and Before November 1, 1996*, Ontario Regulation 776/93, as amended [referred to generally as *SABS*].
• on or between June 22, 1990 and December 31, 1993	• *Insurance Act*, R.S.O. 1980, c.218, as amended by the *Insurance Statute Law Amendment Act*, 1990, and consolidated by the *Insurance Act*, R.S.O. 1990, c.I.8, also known as the *Ontario Motorist Protection Plan ("OMPP")* or **Bill 68**; and • *Statutory Accident Benefits Schedule – Accidents Before January 1, 1994*, Ontario Regulation 672/90, as amended [referred to generally as *SABS*].

These rules DO NOT apply if the accident occurred on or **before** June 21, 1990.

The Annotated Insurance Act of Ontario
Prof. John P. Weir (Toronto, Ont., Carswell, 3 volumes looseleaf)
One Corporate Plaza
2075 Kennedy Road
Toronto ON M1T 3V4
Phone: (416) 298-5141 (ext. 2123)
E-mail: carol.mackay@carswell.com

Ontario Accident Benefits Case Summaries,
Eric K. Grossman, ed. (CCH Canadian Ltd., 1999)
90 Sheppard Avenue East, Suite 300
North York ON M2N 6X1
Fax: (416) 224-2243;
Phone: (416) 224-2224;
1-800-461-5308,
1-800-461-4131
For outside Toronto, phone 1-800-387-5164

QUICKLAW Computer Reporting Services,
1 First Canadian Place, Suite 930
Box 235
Toronto ON M5X 1C8
Fax: (416) 862-8073
Phone: (416) 862-7656
For outside Toronto, phone 1-800-387-0899

An Application for mediation, arbitration, appeal or variation/revocation may be obtained from your insurance company. If you are having difficulty obtaining a form, you may download a single copy from **Section G** of the **Code** posted on FSCO's website at **www.fsco.gov.on.ca** or you may write or telephone the Dispute Resolution Group to have a single copy sent to you, as noted below. The mailing address for all forms is:

Financial Services Commission of Ontario
Dispute Resolution Group
5160 Yonge Street, P.O. Box 85
Toronto ON M2N 6L9

Please specify whether you are seeking a mediation, arbitration or appeal form.

Or, telephone or fax your request for an application pertaining to:

Mediation:
Phone: (416) 250-6714 ext. 7210,
1-800-517-2332 (toll-free), ext. 7210
Fax: (416) 590-7077

Arbitration or Neutral Evaluation:
Phone: (416) 590-7202
1-800-517-2332 (toll-free), ext. 7202
Fax: (416) 590-8462

Appeal, Variation or Revocation:
Phone: (416) 590-7222
1-800-517-2332 (toll-free), ext. 7222
Fax: (416) 590-7077

Bulk orders of forms are available from printers such as:

Informco Inc.
35 Bertrand Avenue
Scarborough ON M1L 2P3
Phone: (416) 285-1700

Proprint Forms
5621 Finch Avenue East, Unit 5
Scarborough ON M1B 2T9
Phone: (416) 754-3028

In what languages are arbitration services provided?

Arbitration hearings may be held in English or French. French language services are provided at the request of the applicant. Interpretation services in other languages may also be provided by the Dispute Resolution Group, as requested by the applicant and required by the arbitrator. The Dispute Resolution Group will pay the cost of interpretation services required at the hearing.

Do I need a lawyer?

A lawyer is not required for arbitration, but many people are represented. Insurance companies are nearly always represented by lawyers at arbitration. You are encouraged to at least consult a lawyer.

What documents are required?

As in mediation, you should have independent documentation about your claim. You and the insurance company should have already exchanged the relevant documents prior to attending a pre-hearing conference. These documents must ultimately be provided to the arbitrator at the pre-hearing and hearing. If necessary, an arbitrator at the pre-hearing may order the production of other important documents. It is in the best interests of both parties to comply with an order for production in a timely manner. See **Practice Note 4** "Exchange of Documents", under **Section C** of the **Code**.

Should I be present at the arbitration hearing?

Yes. Arbitration hearings are usually held in person at the Commission's offices in North York or at locations throughout Ontario. Sometimes the parties can agree to waive an oral hearing and the arbitrator's decision will be based on the documents and written submissions filed.

How long will the arbitration hearing take?

The length of the arbitration process will vary depending on the nature and complexity of the case. The average length of an oral hearing at the Dispute Resolution Group is between two and three days.

Appeal, Variation/Revocation

What should I do if I think the arbitrator's decision is wrong?

If you think that an arbitrator's decision is wrong, two possible procedures are available. First, you can **appeal** the decision, but only where the arbitrator made an error of law. You will not be allowed to appeal simply because you think the arbitrator should have accepted your evidence instead of the other party's.

A ***Notice of Appeal*** **(FORM I)** must be filed within **30 days** of the date of the arbitration decision. The filing fee is **$250**. Appeals are decided by the Director of Arbitrations or a delegate (Director's Delegate).

The second option is an ***Application for Variation/Revocation*** **(FORM L)**. This process is appropriate where the insured person's situation has changed since the arbitration hearing, where new evidence has become available that was not available for the arbitration hearing, or where there is some clear error in the arbitration decision. The filing fee for an ***Application for Variation/Revocation*** is **$250**.

How do I find a lawyer?

The Law Society of Upper Canada offers a lawyer referral service. For more information, phone 1-900-565-4577 ($6.00 fee is charged), and check the Law Society's website at: **www.lsuc.on.ca**, and choose option "Public Legal Information".

User Advisory Groups to the Dispute Resolution Group

The Dispute Resolution Group is fortunate to have two user advisory groups who meet with members of the Dispute Resolution Group's senior management at regularly scheduled meetings throughout the year. The Bar-Dispute Resolution Group Forum ("Counsel Forum") is comprised of lawyers and other representatives who regularly appear on behalf of claimants or insurers within the dispute resolution system. The other group, Companies Forum, is comprised of ADR representatives and claims people from most of the major automobile insurers in Ontario. The members of Companies Forum regularly handle disputed accident benefit claims within our system.

These user groups meet regularly and provide valuable insight and suggestions to the Dispute Resolution Group to ensure that it continues to provide just, flexible, cost effective and efficient dispute resolution services. Further information concerning meeting dates and the minutes of these two advisory groups is available through the FSCO website at **www.fsco.gov.on.ca**.

General information concerning the time lines for the services of the Dispute Resolution Group

1. An insured person or an insurer may apply for mediation of a dispute about an insured person's entitlement to accident benefits where a claim has been denied by the insurer or the time period for the insurer to respond to the claim has elapsed **(Rule 12.1)**.

2. An ***Application for Mediation*** in **FORM A** must be filed with the Dispute Resolution Group no later than **2 years** from the date the insurer provided written notice of a refusal to pay the amount claimed **(Rule 11)**.

3. An ***Application for Mediation*** in **FORM A**, completed in accordance with the requirements of **Rule 12.2**, will be registered and assigned to a mediator within 3 weeks of its receipt.

4. Mediation will be concluded within **60 days** of the registration of the completed ***Application for Mediation*** **(Rule 19)**.

5. A **Report of Mediator (Rule 22)** will be issued within **7 business days** of the conclusion of mediation.

6. An ***Application for Arbitration*** in **FORM C** must be filed with the Dispute Resolution Group no later than **2 years** from the date the insurer provided written notice of a refusal to pay an amount claimed. However, an insured person may file a completed ***Application for Arbitration*** within **90 days** after the mediator reports to the parties in the **Report of Mediator (Rule 11)**.

7. An ***Application for Arbitration*** in **FORM C** will be registered and assigned to an arbitration case administrator within **5 business days** of receipt of an ***Application*** completed in accordance with **Rule 25.1**.

8. Dates for holding an arbitration pre-hearing discussion **(Rule 33)** will be available to the parties within **6 to 8 weeks** from the registration of a completed ***Application for Arbitration***.

9. Dates for holding an oral arbitration hearing will be available to the parties within **4 to 6 months** from the conclusion of the pre-hearing discussion.

10. An oral arbitration hearing is generally concluded within **3 days**.

11. An arbitration order from an oral hearing will be issued within **60 to 85 days** from the conclusion of the oral hearing.

12. A written arbitration hearing is generally concluded within a **60 day** period **(Rule 38)**.

13. An arbitration order from a written hearing will be issued on the later of:

    (a) **60 days** after the last day on which the insured person is entitled to file a ***Reply by the Applicant for Arbitration***;

    (b) **30 days** after the last day on which the parties are required to file additional materials or written submissions **(Rule 38)**.

14. A ***Notice of Appeal*** in **FORM I** on a question of law, must be filed within **30 days** of the date of the arbitration order being appealed **(Rule 52)**.

15. A decision in the appeal will be issued within **60 to 85 days** from the conclusion of the oral or written appeal hearing.

16. A request for an **Assessment of Expenses** must be made within **30 days** from the date the order of the arbitrator was issued **(Rule 79)**.

17. An order on an **Assessment of Expenses** will be issued within **60 to 85 days** from the conclusion of the oral or written hearing on expenses.

HOW DO I GET MORE INFORMATION?

More detailed information is available through the Dispute Resolution Group's recorded telephone information service at (416) 250-6714 or toll free at 1-800-517-2332 or FSCO's website at **www.fsco.gov.on.ca**

PART 1 – GENERAL RULES FOR DISPUTE RESOLUTION

1. INTERPRETATION

1.1 These Rules will be broadly interpreted to produce the most just, quickest and least expensive resolution of the dispute.

1.2 Where something is not specifically provided for in these Rules, the practice may be decided by referring to similar Rules in this **Code**.

1.3 A defect in form or other technical breach will not make a proceeding invalid.

1.4 These Rules are made by the Director under the authority of section 21 of the *Insurance Act* and section 25.1 of the *Statutory Powers Procedure Act*.

1.5 Subject to the requirements of the *Insurance Act* and the *Statutory Powers Procedure Act*, the Director may make changes to these Rules at any time, if he or she considers it appropriate.

1.6 (a) These Rules apply effective May 31, 2001, to all applications for dispute resolution, whenever commenced.

(b) Despite Rule 1.6(a), these Rules do not apply to an arbitration proceeding in which a pre-hearing was held prior to May 31, 2001, unless the parties agree or an arbitrator orders that they apply.

2. GUIDELINES

2.1 The Superintendent of Financial Services, and previously the Commissioner of Insurance, may publish guidelines on the interpretation and operation of the *Statutory Accident Benefits Schedule*. Guidelines are found in **Section B** of the **Code**.

2.2 These guidelines shall be considered when interpreting the *Statutory Accident Benefits Schedule*.

3. PRACTICE NOTES

3.1 The Dispute Resolution Group may issue Practice Notes about policies and administrative procedures. Practice Notes are found in **Section C** of the **Code**.

3.2 Practice Notes are designed to guide users in the dispute resolution process at the Commission. However, they are not binding and do not affect the duty of the adjudicator to make decisions based on the circumstances and merits of each case.

4. DEFINITIONS

4.1 In these Rules:

"accident benefits" means benefits under the *Statutory Accident Benefits Schedule*;

"adjudicator" means the Director or person appointed by the Director under the *Insurance Act* and these Rules to conduct a proceeding requiring the exercise of a statutory power of decision;

"appeal" means an appeal in accordance with section 283 of the *Insurance Act*;

"arbitration" means an arbitration in accordance with section 282 of the *Insurance Act*;

"arbitrator" means an arbitrator appointed by the Director under section 282 of the *Insurance Act*;

"Commission" means the Financial Services Commission of Ontario;

"Director" means the Director of Arbitrations appointed under section 6 of the *Insurance Act* or an employee of the Commission to whom the Director has delegated his or her powers or duties;

"Dispute Resolution Group" means the Dispute Resolution Group of the Commission;

"document" includes written documents, forms, reports, charts, films, photographs, transcripts, videotapes, audio tapes, business and computer files;

"electronic hearing" means a hearing held by conference telephone, or some other form of electronic technology allowing persons to hear one another;

"file" means to file with the Dispute Resolution Group;

"hearing" means the opportunity to state one's case before an adjudicator in the context of an oral, written or electronic hearing;

"mediation meeting" means a scheduled meeting at which the parties and their representatives attend before a mediator in person, by telephone conference or other forms of electronic technology allowing persons to hear one another;

"mediator" means a mediator appointed by the Director under section 280 of the *Insurance Act*;

"neutral evaluation" means an evaluation under section 280.1 of the *Insurance Act* of the probable outcome of a proceeding in court or arbitration;

"neutral evaluator" means a person appointed by the Director under section 280.1 of the *Insurance Act*;

"oral hearing" means a hearing at which the parties attend in person before an adjudicator;

"private arbitration" means an arbitration under the *Arbitration Act, 1991*;

"private neutral evaluator" means a person who has been appointed by the Director under section 280.1 of the *Insurance Act* to perform a neutral evaluation of the probable outcome of a dispute, other than a person appointed to perform the evaluation at the Dispute Resolution Group under **Rule 44** of the **Code**;

"proceeding" means a matter requiring the exercise of a statutory power of decision;

"serve" means the delivery of a document to a person as permitted by these Rules;

"Statutory Accident Benefits Schedule" means any of the following:

(a) the *Statutory Accident Benefits Schedule - Accidents on or after November 1, 1996* for accidents that occur after October 31, 1996; or

(b) the *Statutory Accident Benefits Schedule - Accidents after December 31, 1993* and Before November 1, 1996 for accidents that happened on or between January 1, 1994 and October 31, 1996 inclusive; or

(c) the *Statutory Accident Benefits Schedule - Accidents Before January 1, 1994* for accidents that happened on or between June 22, 1990 and December 31, 1993 inclusive.

"written hearing" means a hearing held by means of the exchange and filing of documents, whether in written form or by electronic means.

5. DISPUTE RESOLUTION SERVICES AND DOCUMENTS

5.1 A person has the right to communicate with the Dispute Resolution Group in French and to receive services in French, as provided in the *French Language Services Act*.

5.2 French language services in mediation, arbitration, neutral evaluation, variation/revocation and appeal are provided at the request of the insured person.

5.3 In mediation, interpretation services in languages other than French and English must be arranged by the party requiring them. The party arranging the interpretation service must pay the cost.

5.4 In arbitration, variation/revocation and appeal hearings, interpretation services in languages other than French and English will be arranged by the Dispute Resolution Group where requested by the insured person and required by the adjudicator. The Dispute Resolution Group will pay the cost of interpretation services required at the hearing.

5.5 Where interpretation services are provided at a hearing, an interpreter must make an oath or affirm that he or she will truly and faithfully translate the evidence.

5.6 The Dispute Resolution Group may issue letters of direction, notices and other documents signed by the Director.

5.7 Where these Rules require the delivery of a document by the Dispute Resolution Group, delivery will be deemed to have occurred where:

(a) one of the methods of delivery permitted under **Rule 7** is used; and

(b) the document is sent to the last known address of the party, contained in the records of the Dispute Resolution Group.

6. FILING

6.1 Where these Rules require a document to be filed:

(a) the document must be delivered to the Dispute Resolution Group;

(b) one of the methods of delivery permitted under **Rule** 7 must be used; and

(c) the time frames set out in **Rule** 7 apply.

7. SERVICE OF DOCUMENTS

7.1 A document must be served by one of the following methods:

(a) personal delivery;

(b) regular, registered, or certified mail;

(c) courier service, including Priority Courier;

(d) facsimile;

(e) document exchange on a person who participates in an exchange service;

(f) electronic transmission; or

(g) any other manner specified by the Director.

7.2 A document that is served by facsimile or electronic transmission must include a cover page indicating:

(a) the name, address, telephone number and electronic transmission address (if any) of the sender;

(b) the name of the individual to be served;

(c) the date and time the document is being sent;

(d) the total number of pages being sent including the cover page; and

(e) the name and telephone number and electronic transmission address (if any) of a person to contact in the event of a problem.

7.3 Service by a party or delivery by the Dispute Resolution Group will be considered to take place within the time frames set out below:

(a) if a document is served by personal delivery, service takes place on the day delivery is made;

(b) if a document is served by regular, registered, or certified mail, service takes place on the fifth day after the date the post office stamps the mailed document;

(c) if a document is served by courier service, including Priority Courier, service takes place on the earlier of receipt, or on the second day after the document is given to the courier;

(d) if a document is served by facsimile or electronic transmission, service takes place on the day that the document is sent;

(e) if the document is served by means of a document exchange on a person who participates in an exchange service, service takes place one day after the deposit, if the document is date-stamped in the presence of the person depositing the document;

(f) if a document is served by any other means specified by the Director, service takes place within the time specified by the Director.

8. CALCULATION OF TIME

8.1 To calculate time under these Rules or an order:

(a) where there is a reference to a number of days between two events, they will be counted by excluding the day on which the first event happens and including the day on which the second event happens;

(b) where the time for doing an act under these Rules ends on a Saturday, Sunday, or a statutory holiday, the act may be done on the next day that is not a Saturday, Sunday, or a statutory holiday; and

(c) filing or service of a document **after 4:45 p.m.** or on a Saturday, Sunday or a statutory holiday will be considered to be made on the next day that is not a Saturday, Sunday, or a statutory holiday.

9. REPRESENTATION

9.1 A party may represent him or herself or may appoint another person to represent him or herself.

(a) Effective November 1, 2003, if the insured person's representative is a non-lawyer who is providing representation for compensation, and is not employed by a law firm and directly supervised by a lawyer, the representative must have met the Superintendent's filing requirements.

(b) A party must provide the Dispute Resolution Group with his or her own name, address, telephone number and electronic transmission address (if any), and if represented, the name, address, telephone number and electronic transmission address (if any) of their representative.

(c) Parties and their representatives must provide the Dispute Resolution Group with written notice of any change of their address, telephone number and electronic transmission address (if any). The Dispute Resolution Group is entitled to rely upon the last known address, telephone number and electronic transmission (if any) contained in its records.

9.2 Subject to **subsection 9.3**, a party who appoints a representative must provide full authorization to the representative to discuss all issues in dispute, to negotiate and to enter into an agreement or settlement of any and all issues in dispute. The Dispute Resolution Group may require written confirmation from the party that a representative has this authority.

9.3 Where an insurer's representative has limited authority to enter into an agreement or settlement, an officer of the company with the requisite authority must attend or be available by telephone for the duration of the mediation, settlement discussion or other proceeding.

9.4 A mediator, neutral evaluator or adjudicator, as the case may be, may adjourn a mediation, neutral evaluation or proceeding, on such terms as he or she considers just, if a party is not present and their representative does not have the requisite authority outlined in subsections 9.2 and 9.3.

9.5 A party who changes his or her representative must promptly notify the former representative, the other parties and the Dispute Resolution Group, in writing, of the name, address, telephone number and electronic transmission address (if any) of the new representative. The new representative must also confirm his or her appointment in writing. The Dispute Resolution Group is entitled to rely on the last written notification concerning a party's representative contained in its files.

9.6 A party who is represented and wishes to act on his or her own behalf, must notify the representative, the other parties and the Dispute Resolution Group, in writing, of the decision to act on his or her own behalf.

9.7 A representative who seeks to withdraw from a proceeding must:

(a) provide a written request for withdrawal, with reasons, to the Dispute Resolution Group and all parties to the proceeding;

(b) provide the last known address, telephone number and electronic transmission address (if any) of the represented party.

9.8 Where the party represented provides written consent to the representative's request for withdrawal, the Registrar or an adjudicator shall permit the representative's withdrawal. Otherwise, an adjudicator may permit the representative to withdraw, subject to such terms as the adjudicator considers just.

9.9 An adjudicator may exclude from a proceeding anyone, other than a duly qualified barrister and solicitor, appearing as a representative or agent on behalf of a party, or as an advisor to a witness, if the adjudicator finds that such person is not competent to properly represent or to advise the party or witness or does not understand and comply with these Rules and the duties and responsibilities of a representative, agent or advisor.

10. PARTY UNDER DISABILITY

10.1 Subject to **Rule 10.2**, a party to a mediation, settlement discussion, neutral evaluation or proceeding is presumed to have the mental capacity to manage his or her property, appoint and instruct a representative, and conduct his or her own case.

10.2 A minor, or a person who has been declared mentally incapable, within the meaning of **Sections 6 or 45** of the *Substitute Decisions Act, 1992, (SDA)* must commence a mediation or other proceeding through:

(a) the Public Guardian and Trustee or a Court appointed guardian of property under the provisions of the *SDA*; or

(b) an attorney under a valid continuing power of attorney that gives the attorney authority over all the property of the party; or

(c) in the case of a minor,

(i) a parent with whom the minor resides;

(ii) a person with lawful custody of the minor;

(iii) a court appointed guardian of the minor's property under the provisions of the *Children's Law Reform Act*; or,

(iv) the Children's Lawyer, in the event there is no person available under subparagraphs (i), (ii), (iii) or if there is a conflict of interest between the minor and such person.

10.3 Where an adult party has not been declared mentally incapable under the provisions of the *SDA*, but exhibits signs of mental difficulty during the course of a mediation, settlement discussion, neutral evaluation or proceeding, either party may request a hearing on a preliminary issue, or the Dispute Resolution Group may direct a hearing on a preliminary issue to determine whether:

(a) the party has the mental capacity to proceed in the dispute resolution process;

(b) there is an attorney with a valid continuing power of attorney over the party's property; or

(c) there is a person such as a spouse, same sex partner, near relative, close friend or a professional such as a doctor, lawyer or business entity, such as a trust company, who has made or intends to make arrangements for the appointment of a guardian over the party's property under the provisions of the *SDA*.

10.4 Parties shall be given written notice of the hearing on a preliminary issue to inquire into a party's mental capacity to proceed in the dispute resolution process.

10.5 Where an adjudicator is not satisfied that a party has the mental capacity to proceed in the dispute resolution process, and there is no attorney or person such as described in **Rule 10.3(b) and (c)**, the adjudicator may appoint a spouse, same sex partner or near relative of the party to act on the party's behalf if that person, in the adjudicator's opinion, is suitable, willing and able to proceed in the dispute resolution process and to receive and administer statutory accident benefits on behalf of the party who has exhibited signs of mental difficulty. The adjudicator may place such conditions or restrictions upon appointments pursuant to this section, as the adjudicator considers reasonable and necessary to protect the interests of the person exhibiting mental difficulty, the other parties to the proceeding and the dispute resolution process.

10.6 Where there is no person such as described in **Rules 10.2, 10.3 or 10.5** available to act, the adjudicator may notify the Public Guardian and Trustee to request that appropriate steps be taken pursuant to the provisions of the *SDA*.

10.7 The representative of a person under a disability under **Rule 10.2** or the representative of a party who has been found to lack the mental capacity to proceed in the dispute resolution process under **Rule 10.5**, shall comply with the approval of settlement requirements of Rule 7.08 of the *Rules of Civil Procedure*.

11. TIME LIMITS FOR MEDIATION, NEUTRAL EVALUATION OR ARBITRATION

11.1 An application for mediation, neutral evaluation or arbitration must be filed no later than **2 years** from the date the insurer provided written notice of a refusal to pay the amount claimed.

11.2 Despite **Rule 11.1**, an insured person may file a completed ***Application for Arbitration*** within **90 days** after the mediator reports to the parties in the **Report of Mediator** or within **30 days** after the neutral evaluator, appointed by the Director, reports to the parties in the **Report of Neutral Evaluator**, whichever is later.

11.3 The limitation period is not extended by the issuance of an amendment to a **Report of Mediator** under **Rule 23.**

12. APPLICATION FOR MEDIATION

12.1 An insured person or an insurer may apply for mediation of any dispute about an insured person's entitlement to accident benefits or the amount of those benefits where a claim has been denied or the prescribed time period for the insurer to respond to the claim has elapsed.

12.2 A party who applies for mediation must file, in duplicate, a completed ***Application for Mediation*** in **FORM A**, which includes:

(a) a description of each issue in dispute;

(b) a list of available documents to which the applicant intends to refer in the mediation;

(c) a list of existing documents that the applicant wishes to obtain from other sources, including the other party, which are required for the purpose of discussing settlement of the dispute; and

(d) if the applicant is the insurer, the name, address, telephone, facsimile number and electronic transmission address (if any) of its company representative.

If available, the applicant should file a copy of the insurer's written explanation of denial or the **Explanation of Benefits Payable by Insurance Company** form.

> For additional guidance on the exchange of documents between the parties, see **Practice Note 4** found in **Section C** of the **Code**.

12.3 If it appears that an ***Application for Mediation*** is incomplete, has been received after the time required for commencing the proceeding has elapsed, exceeds the jurisdiction of the dispute resolution process under the *Act* and its Regulations, or is frivolous, vexatious or an abuse of process, the Dispute Resolution Group will:

(a) deliver written notice of the jurisdictional concerns or deficiencies in the ***Application*** to the applicant and his or her representative; and

(b) hold the ***Application*** in abeyance for **20 days** from the delivery of the notice.

12.4 Where the applicant does not satisfy the jurisdictional concerns or rectify the deficiencies set out in the written notice within the **20 days** provided under **Rule 12.3(b)**, the Dispute Resolution Group may reject the ***Application.***

12.5 A party may not reapply for mediation of any dispute that has been mediated and, according to the Report of Mediator, the dispute was not resolved.

18. CONFIDENTIALITY DURING MEDIATION

18.1 All statements and offers to settle made during mediation, except those contained in the **Report of Mediator**, are deemed to be made for the purpose of settlement and shall not prejudice any position that the parties take in any subsequent arbitration or court proceeding.

18.2 A mediator shall not be required to testify or produce his or her notes or other documents in a civil proceeding or in a proceeding before any board or tribunal respecting a mediation or respecting information obtained in the discharge of the mediator's duties under these Rules.

18.3 Where a party to a mediation provides information to the mediator in confidence, the mediator will not disclose the information without the permission of the party, unless required by law to do so.

18.4 If a party provides documents to a mediator in confidence, the mediator will return the documents to the party and the documents will not form part of the mediation file.

18.5 The Dispute Resolution Group will not provide any part of the mediation file to a neutral evaluator or adjudicator, except the **Report of Mediator**.

19. TIME LIMITS FOR MEDIATION

19.1 Subject to **Rule 19.2**, mediation must be concluded within **60 days** of the filing of an ***Application for Mediation***, completed in accordance with the requirements of **Rule 12**.

19.2 Subject to **Rule 21.1(a)** the parties may agree to extend the **60 day** time limit for mediation.

19.3 Where the parties have agreed to extend the time limit, they must:

(a) consult with the mediator; and

(b) provide the mediator with written confirmation of the dates agreed upon for the extension.

20. SETTLEMENT OF AN ISSUE

20.1 Where the parties settle an issue on their own during the mediation process, they will advise the mediator of the terms of their settlement.

20.2 A settlement is subject to legal requirements, as applicable, including restrictions on settlements within one year of the date of the accident and completion of the appropriate Settlement Disclosure Notice.

See the **Settlement Regulation** found in **Section E** of the **Code**.

21. FAILURE OF MEDIATION

21.1 Mediation has failed on an issue when:

(a) the mediator is of the opinion that mediation will fail and notifies the parties; or

(b) the time limit for mediation, including any extension, has expired and no settlement has been reached.

21.2 If mediation fails on any of the issues in dispute, the insurer will provide the mediator with its last offer in respect of such issue or issues.

21.3 No party may bring a proceeding in any court, refer the issues in dispute to an arbitrator, or agree to submit an issue to private arbitration unless mediation was sought and has failed.

22. REPORT OF MEDIATOR

22.1 The mediator will record the following in the **Report of Mediator**:

(a) the mediator's description of the issues that were in dispute;

(b) if any of the issues were resolved, the terms of any settlement;

(c) the insurer's last offer in respect of any issue that remains in dispute;

(d) any steps the parties agree to take to help them settle any issue that remains in dispute;

(e) a list of documents requested by the parties that have not been produced and that, in the opinion of the mediator, were required for the purpose of discussing settlement of any issue that remains in dispute; and

(f) the mediator's recommendation whether issues that remain in dispute should be referred to neutral evaluation.

22.2 The Dispute Resolution Group will deliver a copy of the **Report of Mediator** to the parties, to a person appointed by the Director to perform a neutral evaluation, and to an arbitrator appointed by the Director.

23. AMENDMENT OF MEDIATOR'S REPORT

23.1 If a party believes that the **Report of Mediator** is not accurate, the party must notify the mediator and the other parties in writing, with reasons, within **10 days** of receiving the **Report**.

23.2 After considering the reasons and the comments of the parties, the mediator may issue an amendment to the **Report of Mediator**, if the mediator considers it appropriate.

23.3 The Dispute Resolution Group will deliver a copy of the amendment to the **Report of Mediator** to the parties, to the person approved by the Director to perform a neutral evaluation, and to an arbitrator appointed by the Director.

24. REFERRAL TO NEUTRAL EVALUATION

24.1 If mediation fails on any of the issues in dispute, the parties jointly or the mediator who conducted the mediation may, for the purpose of assisting in the resolution of the issues in dispute, refer the issues in dispute to a person appointed by the Director for an evaluation of the probable outcome of a proceeding in court or arbitration.

24.2 Where the mediator or the parties jointly refer the issues in dispute to neutral evaluation, the parties shall either:

(a) jointly retain a private neutral evaluator appointed by the Director; or

> See **Practice Note 5** "Mediator Referral to Private Neutral Evaluation" under **Section C** of the **Code**.

(b) If an ***Application for Arbitration*** in **FORM C** is filed, jointly request neutral evaluation at the Commission in accordance with the Rules under **PART 3, ARBITRATION AND NEUTRAL EVALUATION AT THE COMMISSION.**

> See **Practice Note 6** "Neutral Evaluation at the Financial Services Commission" under **Section C** of the **Code**.

24.3 The Director will promptly appoint a person to conduct a private neutral evaluation under **Rule 24.2(a)** upon receipt in writing of:

(a) the name, address, telephone number and electronic transmission address (if any) of the person who has been jointly retained by the parties;

(b) confirmation from the person jointly retained that he or she has agreed to perform the neutral evaluation at the parties' expense and in accordance with the requirements of the *Insurance Act*; and

(c) confirmation of the applicable mediation file number.

24.4 Where the issues in dispute are referred to neutral evaluation, no party may proceed to court or arbitration unless the report of the person who performed the neutral evaluation has been given to the parties.

PART 3 – ARBITRATION AND NEUTRAL EVALUATION AT THE COMMISSION

25. APPLICATION FOR ARBITRATION

25.1 An insured person applying for arbitration (the "applicant") must file a completed ***Application for Arbitration*** in **FORM C**, which includes:

(a) a description of each issue to be arbitrated, provided the issues were submitted to mediation and failed;

(b) an explanation why any document identified in the **Report of Mediator** as having been requested by the insurer, has not been provided to the insurer;

(c) a list of other key documents in the applicant's possession to which he or she intends to refer in the arbitration;

(d) a list of key documents the applicant intends to obtain from other sources, including those the applicant requests from the insurer, such as surveillance evidence;

(e) payment of the application filing fee set out in **Section D** of the **Code**; and

(f) an indication whether the applicant prefers an oral, electronic or written hearing.

25.2 The applicant must also:

(a) file a copy of the **Report of Mediator** related to the issues to be arbitrated; and

(b) where an evaluation by a private neutral evaluator has occurred, file the **Report of the Neutral Evaluator** or confirmation that the parties have received a copy of it.

25.3 The insured person may request neutral evaluation at the Commission in the ***Application for Arbitration***, unless an evaluation by a private neutral evaluator has occurred. Neutral evaluation at the Commission will be conducted according to **Rules 44** and following:

> See **Practice Note 6** "Neutral Evaluation at the Financial Services Commission of Ontario" under **Section C** of the **Code**.

25.4 If it appears that an ***Application for Arbitration*** is incomplete, has been received after the time required for commencing the proceeding has elapsed, exceeds the jurisdiction of the dispute resolution process under the *Insurance Act* and its Regulations, or is frivolous, vexatious or an abuse of process, the Dispute Resolution Group will:

(a) deliver written notice of the jurisdictional concerns or deficiencies in the ***Application*** to the applicant and his or her representative; and

(b) hold the ***Application*** in abeyance for **20 days** from the delivery of the notice.

25.5 Where the applicant does not satisfy the jurisdictional concerns or rectify the deficiencies set out in the written notice within the **20 days** provided under **Rule 25.4(b)**, an arbitrator may reject the ***Application***.

25.6 The Dispute Resolution Group will deliver a copy of the completed ***Application for Arbitration*** to the other parties.

26. OPTIONS AVAILABLE TO AN INSURER, INCLUDING NEUTRAL EVALUATION AT THE COMMISSION

26.1 Within **20 days** of receipt by the insurer of the ***Application for Arbitration***, the insurer must respond in **one** of the following ways:

(a) serve and file a ***Response by Insurer*** in **FORM E**, completed in accordance with **Rule 27**, together with a ***Statement of Service*** in **FORM F**; or

(b) if the insured person has requested neutral evaluation at the Commission, the insurer must file an ***Agreement to Neutral Evaluation***, in **FORM D**, by facsimile transmission; or

(c) unless a private neutral evaluation has occurred, the insurer may request neutral evaluation at the Commission by obtaining the written consent of the applicant, and filing an ***Agreement to Neutral Evaluation*** in **FORM D**, by facsimile transmission.

26.2 Where the parties jointly choose Neutral Evaluation at the Commission, it shall be conducted according to **Rules 44** and following.

27. RESPONSE BY INSURER

27.1 Where parties do not jointly choose neutral evaluation, the ***Response by Insurer*** in **FORM E** must include:

(a) a response to each issue raised in the ***Application for Arbitration***;

(b) a description of any additional issues that the insurer wishes to have arbitrated, provided the issues were submitted to mediation and failed;

(c) an explanation why any document identified in the **Report of Mediator** as having been requested by the applicant, has not been provided to the applicant;

(d) a list of other key documents in the insurer's possession to which it intends to refer in the arbitration, including surveillance evidence;

(e) a list of key documents the insurer intends to obtain from other sources, including those the insurer requests from the applicant; and

(f) an indication whether the insurer prefers an oral, electronic or written hearing.

27.2 If it appears that a ***Response by Insurer*** is incomplete or exceeds the jurisdiction of the dispute resolution process under the *Insurance Act* and its Regulations, the Dispute Resolution Group will:

(a) deliver written notice of the jurisdictional concerns or deficiencies in the ***Response*** to the Insurer and its representative; and

(b) hold the ***Response*** in abeyance for **20 days** from the delivery of the notice.

27.3 Where the Insurer does not satisfy the jurisdictional concerns or rectify the deficiencies set out in the written notice within the **20 days** provided under **Rule 27.2**, an arbitrator may reject the ***Response*** and the arbitration will proceed on an uncontested basis.

28. Appointment of an arbitrator

28.1 Where the Director has not appointed a private neutral evaluator under **Rule 24.3** or a neutral evaluator at the Commission under **Rule 44.1**, the Director will promptly appoint an arbitrator. The Director may also appoint an arbitrator to conduct a pre-hearing or other interim proceeding.

29. Reply by the applicant for arbitration

29.1 Within **10 days** of being served with the ***Response by Insurer***, the applicant must reply to any new issues raised by:

(a) serving a ***Reply by the Applicant for Arbitration*** in **FORM G** on the insurer and any other parties; and

(b) filing a copy of the ***Reply*** together with a ***Statement of Service*** in **FORM F**.

29.2 The Reply by the ***Applicant for Arbitration*** is optional where no new issues are raised in the Response by Insurer.

30. Combining applications

30.1 Where two or more ***Applications for Arbitration*** have been filed and it appears that:

(a) they have an issue or question of law, fact, or policy in common; or

(b) the application of this Rule will result in the most just, quickest, and least expensive means to deal with the ***Applications***;

The Dispute Resolution Group will notify the parties in writing of the intention to:

(c) combine the proceedings;

(d) schedule the proceedings to be heard at the same time;

(e) schedule one or more proceedings to be heard one immediately after the other by the same arbitrator; or

(f) suspend the scheduling of a proceeding or proceedings until the determination of any one of them.

30.2 Where a party objects to a notice made under **Rule 30.1**, the party must promptly notify the Dispute Resolution Group and the other parties involved, in writing, of the objection.

30.3 An arbitrator will consider an objection made under **Rule 30.2** and make an order on such terms as he or she considers just.

31. SEVERING ISSUES

31.1 Where an arbitrator considers it appropriate, or where the parties agree and the arbitrator approves, the Dispute Resolution Group will notify the parties in writing that an ***Application for Arbitration*** in **FORM C** is to be divided into distinct issues to be heard separately.

31.2 If more than one final order is made in an application, each order will stand on its own for the purposes of an appeal or a variation/revocation proceeding.

31.3 Where a party objects to a notice made under **Rule 31.1**, the party must promptly notify the Dispute Resolution Group and the other parties involved, in writing, of the objection.

31.4 An arbitrator will consider the objection and may make an order on such terms as he or she considers just.

32. EXCHANGE OF DOCUMENTS BEFORE PRE-HEARING

32.1 At least 10 days before the pre-hearing discussion, each party must:

(a) exchange all documents identified in the Application for Arbitration and the Response by Insurer, or explain why a document has not been provided;

(b) establish reasonable time frames for the exchange of any remaining documents;

(c) file the key documents the pre-hearing arbitrator will require to understand the issues in dispute;

(d) file a list of outstanding document requests and identify any disputed items.

32.2 Subject to the time lines under **Rule 39**, the parties have an ongoing responsibility to ensure the prompt and complete exchange of documents that are reasonably necessary to determine the issues being arbitrated, including updates to the information previously exchanged and any additional documents obtained.

32.3 Subject to **Rule 39**, an arbitrator may at any time order the production of documents or the giving of information that he or she considers relevant to the determination of the issues in the arbitration, on such terms as he or she considers appropriate.

33. PRE-HEARING DISCUSSION

33.1 One or more pre-hearing discussions may be held before an arbitrator who will attempt to resolve the dispute, and will assist the parties to prepare for the arbitration by:

(a) identifying and obtaining agreement as to the issues for arbitration;

(b) obtaining agreement as to facts;

(c) deciding any disputes relating to the identification and exchange of documents, making orders and setting time lines for the exchange of outstanding documents;

(d) dealing with procedural and preliminary issues, and requests for interim relief or interim expenses;

(e) identifying the expert and lay witnesses to be called at the hearing and determining the length of hearing;

(f) setting dates for the hearing;

(g) arranging the form in which document briefs or a joint book of documents will be submitted to the hearing arbitrator; and

(h) dealing with any other matters that the arbitrator considers appropriate.

33.2 A pre-hearing discussion may be held in person, by telephone conference call, electronically, or by any other means that the pre-hearing arbitrator considers appropriate.

33.3 The Dispute Resolution Group will provide parties with reasonable notice of the date and manner of the pre-hearing discussion.

33.4 The pre-hearing arbitrator will confirm the results of the pre-hearing discussion to the parties in writing.

33.5 An arbitrator who presides at a pre-hearing discussion at which the parties attempt to settle some or all of the issues in dispute will not preside at the hearing unless the parties consent.

34. FAILURE TO COMPLY

34.1 Where a party fails to comply with a time requirement established by these Rules or by order or agreement, or fails to produce documents in compliance with an order or agreement, an arbitrator may:

(a) order a party to pay expenses (including interim expenses), or deny expenses to a party;

(b) exclude a document filed;

(c) impose a new timetable for compliance;

(d) draw an adverse inference against a party; and

(e) make such other order as the arbitrator considers just.

34.2 Either party may make a written request for the resumption of a pre-hearing discussion where a party fails to comply with a time requirement established by these Rules or by order or agreement, or fails to produce documents in compliance with an order or agreement.

34.3 The Dispute Resolution Group will attempt to accommodate a party's written request for a resumption of the pre-hearing discussion where practicable.

35. SETTLEMENT CONFERENCE PRIOR TO SCHEDULED HEARING DATE

35.1 Either party may contact the Dispute Resolution Group to request a settlement conference.

35.2 The party seeking the settlement conference should confirm the consent of all other parties to the settlement conference and provide times and dates for the conference that are acceptable to all parties.

35.3 The Dispute Resolution Group will attempt to accommodate a joint request of the parties for a settlement conference and may assign a mediator or adjudicator to facilitate resolution of the issues in dispute.

35.4 The Dispute Resolution Group or an arbitrator may also initiate a settlement conference, provided the parties consent.

35.5 An arbitrator who facilitates a settlement conference prior to the scheduled hearing shall not preside at the hearing unless the parties consent.

36. CONFIDENTIALITY DURING SETTLEMENT DISCUSSIONS

36.1 No statements made for the purpose of settlement or any offer to settle made during a pre-hearing discussion or settlement conference shall prejudice any position the parties may take in any subsequent proceeding.

36.2 No person appointed to facilitate the settlement of an issue in dispute before the Dispute Resolution Group shall be compelled to give testimony or produce his or her notes or other documents in a proceeding before the Dispute Resolution Group, in a private arbitration or civil proceeding through the courts, with respect to matters that come to his or her knowledge in the course of exercising his or her duties under these Rules, the *Insurance Act*, or its Regulations.

37. HEARINGS

37.1 The arbitrator may:

(a) hold an oral hearing;

(b) hold a written hearing;

(c) hold an electronic hearing; or

(d) hold a hearing which combines one or more of the above formats.

37.2 The arbitrator will not hold a written hearing where a party satisfies the arbitrator that there is a good reason for not doing so.

37.3 The arbitrator will not hold an electronic hearing where a party satisfies the arbitrator that holding an electronic hearing will significantly prejudice the party.

37.4 **Rules 37.2 and 37.3** do not apply if the only purpose of the hearing is to deal with procedural matters.

37.5 The parties to an arbitration shall be given reasonable notice of a hearing, the manner of the hearing and in the case of a written or electronic hearing, a

statement that either party may object to a written or electronic hearing on the grounds set out in **Rules 37.2 and 37.3** (except in the case of a hearing on procedural matters only).

37.6 The arbitrator will determine all issues in dispute and such other issues as the parties may agree, where mediation has taken place.

37.7 Where notice of hearing has been sent to a party and a party does not attend at an oral or electronic hearing, or participate in a written hearing, the arbitrator may proceed with the hearing in the party's absence or without the party's participation, as the case may be, and the party is not entitled to any further notice in the proceeding.

38. TIME LINES FOR WRITTEN HEARINGS

38.1 In a written hearing, the arbitrator:

(a) may, within **30 days** after the last day on which the insured person is entitled to file a ***Reply by the Applicant for Arbitration***, request additional materials or written submissions from the parties on any issue or matter in dispute;

(b) may proceed to determine the issues even though a party has failed to file additional materials or written submissions, if the arbitrator is satisfied that the Dispute Resolution Group has delivered the request for additional materials or submissions;

(c) will make the order based on the materials and submissions filed;

(d) will issue an order on the later of:

(i) **60 days** after the last day on which the insured person is entitled to file a ***Reply***; and

(ii) **30 days** after the last day on which the parties are required to file additional materials or written submissions.

39. EVIDENCE

39.1 Subject to **Rule 39.2**, all documents, reports (including experts' reports) and assessments to be introduced at a hearing by either party must be served on the other party at least **30 days** before the first day of the hearing.

39.2 In extraordinary circumstances, a party may seek an arbitrator's permission to serve a document, report or assessment on the other party for use at a hearing less than **30 days** before the first day of hearing.

39.3 The hearing arbitrator will determine the relevance, materiality, and admissibility of evidence submitted at the hearing, but will not admit evidence at a hearing that:

(a) would not be admissible in a court by reason of any privilege under the law of evidence; or

(b) is not admissible under the *Insurance Act*; or

(c) was not served on the opposing party in accordance with **Rules 39.1 and 39.2,** unless the hearing arbitrator is satisfied that extraordinary circumstances exist to justify an exception.

40. SURVEILLANCE EVIDENCE

40.1 If a party intends to rely on any portion of surveillance or investigative evidence, including videotapes, photographs, reports, notes and summaries of surveillance observations or investigations, at least 30 days before the hearing, the party shall provide:

(a) the names and qualifications of the persons who secured the investigative or surveillance evidence, the dates, times and places where any surveillance or investigation was undertaken; and

(b) copies of all videotapes, photographs, investigative reports, notes and summaries taken or prepared in connection with the issues in dispute.

41. WITNESSES

41.1 Each party must provide the other parties with the names of witnesses that the party intends to call and the names of persons the party requires to attend for cross-examination on a report, at least **30 days** before the first day of the hearing.

41.2 Every party must notify a potential witness of the intention to call him or her to give evidence at the hearing at least **30 days** before the first day of the hearing.

41.3 An arbitrator may:

(a) excuse a witness from attending at the hearing, if the witness was not identified at the pre-hearing under **Rule 33**, or notified at least **30 days** before the first day of hearing under **Rule 41.2**; or

(b) make such other order as the arbitrator considers just.

64. APPLICABILITY OF THIS PART

64.1 This Part applies to all arbitrations, appeals, interventions and variation/revocation proceedings.

65. ORDERS

65.1 An adjudicator will determine the issues before him or her by order and may make an order subject to such terms as he or she considers just.

65.2 An adjudicator may make an oral order with oral reasons where he or she considers it appropriate. The adjudicator will confirm the provisions of an oral order in writing if requested by the parties at the conclusion of the oral order.

65.3 An order which finally decides the issues in dispute will be supported by written reasons.

65.4 The Dispute Resolution Group will deliver a copy of the order and the adjudicator's written reasons, if any, to the parties.

65.5 An adjudicator may, at any time, correct a typographical error, error of calculation, technical error or similar error made in his or her decision or order.

65.6 An adjudicator may at any time clarify a decision or order that contains a misstatement, ambiguity or other similar error.

65.7 An adjudicator may make such orders or give such directions as he or she considers proper to prevent an abuse of process.

66. COURT ENFORCEMENT OF ORDERS

66.1 On written request, the Director will provide a party with a certified copy of an order.

66.2 A party may file a certified copy of an order in the Ontario Superior Court of Justice and the order can be enforced by the Court in the same manner as an order of that Court.

66.3 A party who files an order under **Rule 66.2** shall notify the Director within **10 days** after the filing.

67. ORDERS WITHIN PROCEEDING: MOTIONS

67.1 An adjudicator may make preliminary or interim orders within a proceeding, pending a final order.

67.2 A party may request a preliminary or interim order, at any stage within a proceeding, pending a final order.

67.3 A party making such a request must, in writing:

(a) describe the order being sought, the grounds for the order, and provide any documents to be relied on;

(b) set out the time, date and manner in which the party seeks to have the motion heard; and

(c) serve this material on the other parties and file it.

67.4 Where a party seeks an order for production against a person who is not a party to the proceeding ("third party"), the party making the request must serve the materials required under **Rule 67.3**, upon the third party and file it together with a ***Statement of Service*** in **FORM F**.

67.5 Within **10 days** of being served, the responding party and third party, if any, must:

(a) serve a written response and documents to be relied on; and

(b) file a copy of the written response and documents.

67.6 The adjudicator may determine the request on the basis of the documents and written submissions filed, or in such manner as the adjudicator considers appropriate.

67.7 Before making an order for the production of documents against a third party, the adjudicator shall be satisfied that:

(a) the parties have made reasonable efforts to obtain the document sought;

(b) the document sought is in the possession, control or power of the third party;

(c) the third party has had a reasonable opportunity to respond;

(d) the document is reasonably required to ensure a just and fair hearing.

67.8 A request for an interim order or an order on a preliminary issue may also be made orally during a pre-hearing discussion, a preliminary conference, or at a hearing, and will be dealt with in such manner as the adjudicator considers appropriate.

68. DISMISSAL OF PROCEEDING WITHOUT HEARING

68.1 Subject to **Rule 68.2**, an adjudicator may dismiss a proceeding without a hearing where the proceeding is frivolous, vexatious or is commenced in bad faith.

68.2 Before dismissing a proceeding under this Rule, an adjudicator shall deliver written notice to all parties of the intention to dismiss the proceeding on the grounds set out in **Rule 68.1.**

68.3 Where a party objects to a dismissal of the proceeding pursuant to **Rule 68.1** or seeks to make written submissions with respect to the dismissal, the party must:

(a) provide the grounds upon which the party objects to the dismissal of the proceeding, or set out any other issues or concerns, in writing; and

(b) serve the material upon the other parties and file it within **20 days** of the date of the notice provided under **Rule 68.2.**

68.4 An adjudicator will consider any written objections or submissions received and may make an order on such terms as he or she considers just.

69. SETTLEMENT

69.1 The parties may settle any or all issues in dispute at any time, provided at least one year has passed since the date of the accident, or a pre-hearing conference has been completed.

69.2 If a dispute is settled, the Dispute Resolution Group will close its file:

(a) immediately upon receipt of written confirmation from the parties that the entire matter is settled; or

(b) **20 days** following notice of the Dispute Resolution Group's intention to close the file on the basis of a reported settlement.

69.3 Where a party objects to the closure of a file under **Rule 69.1(b)**, the party must promptly notify the Dispute Resolution Group and all other parties, in writing, setting out the reasons for the objection.

69.4 Either party may request an adjudicator to issue an order dismissing the proceeding on consent of the parties, upon filing:

(a) a consent, signed by the parties or their representatives, stating that they consent to the dismissal of the arbitration and confirming that no party to the proceeding is under a disability;

(b) a signed Settlement Disclosure Notice;

(c) the written agreement of the parties that the consent order is final and shall not be subject to appeal, variation/revocation, or judicial review; and

(d) three copies of the consent order, approved as to form and content by the parties, for delivery by the Dispute Resolution Group.

70. WITHDRAWAL

70.1 A party may seek permission to withdraw all or part of a dispute by:

(a) serving a request to withdraw on all parties; and

(b) filing the request to withdraw together with a ***Statement of Service*** in **FORM F**; or

(c) making an oral request to withdraw all or part of a dispute during a neutral evaluation, pre-hearing discussion, settlement discussion, preliminary conference or at a hearing.

70.2 An adjudicator may permit a party to withdraw all or part of a dispute where all parties agree.

70.3 Where a party does not agree to the withdrawal, an adjudicator may:

(a) permit the withdrawal on such terms and conditions as he or she considers just;

(b) award expenses to either party as permitted by **Rule 75** and following.

71. INABILITY OF AN ADJUDICATOR TO COMPLETE A HEARING

71.1 If an adjudicator becomes unable, for any reason, to complete a hearing or issue a decision, the matter may be reheard by a new adjudicator appointed by the Director.

71.2 Where a transcript of the incomplete hearing is available, the Director may notify the parties of the Director's intention to provide a copy of the transcript to the new adjudicator, with a copy to the parties, at the Dispute Resolution Group's expense; where the Director considers it appropriate, or where the parties agree and the Director approves.

71.3 Where a party objects to the use of the transcript by the new adjudicator, the party must promptly notify the Director and all other parties in writing, setting out the reasons for the objection.

72. ADJOURNMENTS

72.1 A request for an adjournment of a pre-hearing discussion or an arbitration proceeding must be made in writing to the Dispute Resolution Group. A request for an adjournment of an appeal or variation/revocation proceeding must be made in writing to the Director, or to the person delegated by the Director to decide the matter. Such requests must:

(a) outline the reasons for the adjournment;

(b) indicate whether all parties consent to the adjournment; and

(c) provide alternative dates that are acceptable to all parties.

72.2 A request for an adjournment must be served on the other parties and filed **7 days** in advance of the scheduled proceeding or such lesser period of time as the adjudicator may permit.

72.3 In deciding whether an adjournment is appropriate, the adjudicator shall refer to the **Adjournments Policy** found in **Practice Note 9** under **Section C** of the **Code**.

72.4 An adjudicator may adjourn a proceeding on his or her own initiative, or at the request of a party, on such terms he or she considers just.

72.5 An adjudicator may require the parties to attend in person to argue an adjournment, even if it is on consent.

73. SUMMONS TO WITNESS

73.1 An adjudicator has the same powers to summons as a judge of the Ontario Superior Court of Justice. The adjudicator may, by ***Summons to Witness***, require a person to:

(a) attend at or participate in a hearing, and to give evidence on oath or otherwise; and

(b) produce in evidence documents and things set out in the summons.

73.2 If a person does not attend or participate in a hearing or does not produce the documents listed in the ***Summons to Witness*** (**FORM N**), a judge of the Ontario Superior Court of Justice may order that a warrant for the arrest of that person be issued or that the person be punished in the same way as for contempt of that court.

73.3 A ***Summons to Witness*** must be prepared in **FORM N**.

73.4 The party requesting the summons must:

(a) ensure that the ***Summons to Witness*** is served personally on the person summoned not less than **5 business days** before the first day of the hearing, or within such shorter time period as the adjudicator considers just;

(b) pay the person summoned the same fees or allowances as are paid to a person summoned to attend before the Ontario Superior Court of Justice; and

(c) file an ***Affidavit of Service for a Summons to Witness*** in **FORM O** as proof that the ***Summons*** was properly served and that the required fees or allowances have been paid.

> See **Practice Note 8** "Attendance of a Witness to an Arbitration Hearing by Summons" found in **Section C** of the **Code**.

73.5 An adjudicator may excuse a witness from the obligation to attend at or participate in a hearing where notice under **Rules 33, 41 and 73.3** has not been provided to the witness.

74. TRANSCRIPTS

74.1 A hearing may be recorded by a court reporter who has taken an oath or affirmation to report the evidence and proceedings faithfully. The Dispute Resolution Group does not provide reporting services for a hearing. Parties who want a record of the proceedings must make their own arrangements for the attendance of a reporting service, and must pay for this service.

74.2 Where a party hires a reporting service to record the proceedings, the party must:

(a) inform the other parties and the adjudicator;

(b) make the necessary arrangements for the reporting service; and

(c) directly pay the person or agency providing the reporting service.

74.3 Where a party orders all or a portion of the transcript of a proceeding, the party must:

(a) inform the other parties and the adjudicator;

(b) provide a copy of the transcript to the other party and the adjudicator; and

(c) directly pay the person or agency providing the transcript.

75. AWARD OF EXPENSES

75.1 An adjudicator may award expenses to a party if the adjudicator is satisfied that the award is justified having regard to the criteria set out in **Rule 75.2.** The items and amounts which may be awarded are found in **Rule 78** and the **Schedule** to the **Expense Regulation** found in **Section F** of the **Code**.

75.2 The adjudicator will consider only the criteria referred to in the **Expense Regulation** found in **Section F** of the **Code.** These criteria are:

(a) each party's degree of success in the outcome of the proceeding;

(b) any written offers to settle made in accordance with **Rule 76;**

(c) whether novel issues are raised in the proceeding;

(d) the conduct of a party or a party's representative that tended to prolong, obstruct or hinder the proceeding, including a failure to comply with undertakings and orders;

(e) whether any aspect of the proceeding was improper, vexatious or unnecessary.

76. OFFER TO SETTLE

76.1 An adjudicator will consider an **Offer to Settle** in connection with an award of expenses provided that:

(a) it was made in writing, was served on the other parties and contains:

(i) the full terms of the **Offer to Settle;**

(ii) the date when the **Offer** was served and the time period during which it remained open for acceptance;

AND

(b) the **Offer** was made after the conclusion of mediation and before the conclusion of the hearing, with particular consideration given to any **Offer** served after the conclusion of the pre-hearing discussion or preliminary conference as the case may be, up to 5 days before the commencement of the hearing.

76.2 **Response to an Offer to Settle** will be considered provided that:

(a) it was made in writing, indicates the **Offer** to which it relates; and

(b) it was served upon the other parties before the conclusion of the hearing.

76.3 An **Offer to Settle** or **Response to an Offer to Settle** may be withdrawn at any time before it is accepted, by serving written notice of the withdrawal on the party to whom the offer or response was made.

76.4 An **Offer** or **Response** will expire on the earlier of the expiry date stated in the **Offer** or **Response**, or at the conclusion of the hearing.

76.5 Acceptance of an **Offer** or **Response** must be made in writing and served upon the party making the **Offer** or **Response**, prior to the withdrawal or expiry of the offer.

77. COMMUNICATION OF AN OFFER TO SETTLE OR RESPONSE TO AN OFFER TO SETTLE

77.1 When no party to an adjudication seeks to have an **Offer to Settle** or a **Response to an Offer to Settle** considered by the adjudicator in connection with an award of expenses, the parties will jointly inform the adjudicator of that fact at the conclusion of the hearing; and the adjudicator will make an award of expenses as part of his or her order on the substantive issues in dispute.

77.2 Where any party seeks to have an **Offer to Settle** or a **Response to an Offer to Settle** considered by the adjudicator in connection with an award of expenses, the parties will jointly advise the adjudicator of that fact at the conclusion of the hearing.

77.3 Upon such advice, the adjudicator will determine all issues in dispute, except expenses and issue his or her order.

77.4 The Dispute Resolution Group will deliver a copy of the order (excluding expenses) and the adjudicator's written reasons, if any, to the parties.

77.5 Within **10 days** of the delivery of the order, either party may file any relevant **Offer to Settle** or **Response to an Offer to Settle** which was made in accordance with **Rule 76**, for consideration by the adjudicator in connection with an award of expenses.

77.6 Either party may request an appointment before an adjudicator for an award of expenses or an assessment of expenses in accordance with **Rule 79**.

81.2 Any procedural requirement set out in the *Insurance Act* or the *Statutory Powers Procedure Act* that applies to a hearing held under these Rules may be set aside with the agreement of the parties and the adjudicator.

82. TESTIMONY AND CIVIL PROCEEDINGS

82.1 An adjudicator shall not be required to testify in a civil proceeding or in a proceeding before any other tribunal respecting information obtained in the discharge of his or her duties.

SECTION B – GUIDELINES

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2. Guideline for Statutory Accident Benefits Applications, the Claims Process and the Mediation Process (Bill 59) ..... B 2-1

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GUIDELINE ON DESIGNATED ASSESSMENT CENTRE SELECTION PROCESS

Introduction

Regulation 313/03, which comes into effect on October 1, 2003, changes the process under section 53 of the Statutory Accident Benefits Schedule (SABS) for selecting a Designated Assessment Centre (DAC) to conduct a designated assessment. Effective October 1, 2003, the SABS no longer requires a claimant to be assessed at the DAC closest to his or her residence.

Section 53 of the SABS, as amended effective October 1, 2003, is attached to this Guideline for reference.

This Guideline defines the process by which the Superintendent will select a DAC under section 53 of the SABS.

Notification/Termination

In the event that a benefit is disputed by an insurance company, the insurance company is required to give the claimant an explanation of benefits payable, and notice of assessment, denial, reduction or termination of benefits through the provision of the following forms as appropriate:

- OCF-9 Explanation of Benefits Payable by Insurance Company
- OCF-17 Notice of Stoppage of Weekly Benefits and Request for Assessment
- OCF-20 Catastrophic Impairment Determination and Request for Assessment

These forms are also to be used by a claimant who wishes to dispute the insurance company's assessment, denial, reduction or termination of benefits and be assessed at a DAC.

Both the OCF-9 and the OCF-17 provide a general overview of the claimant's right to dispute.

Selection of a DAC by Agreement of Insurer and Claimant

As amended, section 53 of the SABS requires that if an insurer receives a notice of a claimant's request for a DAC assessment, or determines that a DAC assessment is required under the SABS, the insurer and the claimant should attempt to jointly select the DAC.

The selection is to be made no later than the second business day after the insurer or the claimant, as the case may be, receives notice from the other that a DAC assessment is required under the SABS.

If the insurer and the claimant do jointly select a DAC, the insurer will initiate the referral to the DAC and indicate on a DAC Referral, Plan, and Summary Form (OCF-11) that the DAC referral is being made jointly by the insurer and the claimant.

If the DAC is unable to begin the assessment within 14 days from the date of receiving the request for assessment, the parties will attempt to jointly select another DAC, subject to the provisions of the SABS.

Superintendent Selection of a DAC

The Superintendent will select a DAC if:

- the insurer and the claimant do not jointly select a DAC within two business days; or
- the DAC jointly selected by the parties is unable to begin an assessment within 14 days of the request for an assessment, and the parties ask the Superintendent to select another DAC.

Superintendent's Protocol for DAC Selection Process

1. In the event that the insurer and the claimant do not jointly select a DAC, the insurer must request that the Superintendent select a DAC on behalf of the parties.

2. The insurer representative is required to initiate the process via the DAC Selection Request form that can be downloaded (in WordPerfect or Word format) from the *DAC Selection* page on FSCO's website at www.fsco.gov.on.ca.

3. The insurer representative is required to complete the request and certify that the information is accurate. The insurer will attach the request to an e-mail and send it to FSCO at dacselection@fsco.gov.on.ca.

4. Within two business days, FSCO will send to the insurer representative, via e-mail, a confirmation certificate specifying the DAC selected. Each certificate will have a FSCO file number that can be used for verification.

5. The insurer must initiate a referral to the specified DAC by completing an OCF-11, printing a copy of the confirmation certificate, and attaching the copy of the certificate to the OCF-11. The insurer is also required to ensure the claimant or the claimant's legal representative receives a copy of the certificate.

6. Insurers and claimants are prohibited from using this process to make more than one request for selection of a DAC unless one of the following conditions applies:

   (a) The DAC previously selected by the Superintendent has declared a conflict of interest that is not being waived by the parties; or

   (b) The DAC previously selected by the Superintendent is unable to conduct the assessment within the required time frame; or

(c) The claimant is being sent for an additional assessment as required by the SABS (e.g. subsequent disability assessment or multiple treatment plans), and the parties do not jointly select a DAC in the manner required by the SABS.

Section 53 of the Statutory Accident Benefits Schedule as amended effective October 1, 2003

53. (1) A designated assessment shall be conducted by a designated assessment centre selected in accordance with this section.

(1.1) A designated assessment must be conducted by a designated assessment centre that,

(a) is authorized to assess impairments of the type sustained by the insured person; and

(b) is authorized to conduct the type of designated assessment that is required.

(1.2) A designated assessment must be conducted by a designated assessment centre that is located within,

(a) 30 kilometres of the insured person's residence, if,

(i) the insured person's residence is located in the City of Toronto or the regional municipality of Durham, Halton, Peel or York, and

(ii) a designated assessment centre that complies with subsection (1.1) is located within 30 kilometres of the insured person's residence; or

(b) 50 kilometres of the insured person's residence, if,

(i) the insured person's residence is not located in the City of Toronto or the regional municipality of Durham, Halton, Peel or York, and

(ii) a designated assessment centre that complies with subsection (1.1) is located within 50 kilometres of the insured person's residence.

(1.3) Subject to subsections (1.1) and (1.2), the insurer and the insured person may jointly select the designated assessment centre if the selection is made not later than the second business day after the insurer or the insured person, as the case may be, receives notice from the other that a designated assessment is required under this Regulation.

(1.4) If the insurer and the insured person do not jointly select the designated assessment centre in accordance with subsection (1.3), the Superintendent shall, subject to subsections (1.1) and (1.2), select the designated assessment centre.

(2) If the designated assessment centre is selected by the Superintendent, the designated assessment centre shall, before conducting the designated assessment, give the insurer and the insured person notice disclosing any conflict of interest that the centre has relating to the designated assessment.

(3) The designated assessment centre shall give any notice required under subsection (2) in respect of a designated assessment described in subsection 43 (11) within three business days after receipt of the request for the designated assessment.

(4) If a conflict of interest is disclosed under subsection (2),

(a) the designated assessment centre shall conduct the designated assessment if the insurer and the insured person agree; or

(b) if the insurer and the insured person do not agree, the designated assessment shall be conducted, subject to subsections (1.1), (1.2) and (2), by another designated assessment centre selected by the Superintendent.

(5) For the purposes of clause (4) (b), the insurer and the insured person shall be deemed not to agree in the case of a designated assessment described in subsection 43 (11) unless they agree by the end of the third business day after the day the insurer receives the notice under subsection (2) or the insured person receives the notice under subsection (2), whichever day is later.

[subsections (6), (7) & (8) are revoked]

(9) Except as otherwise required under subsection 43 (11), a designated assessment centre must begin a designated assessment within 14 days after receiving a request for the designated assessment.

(10) If a designated assessment centre is unable to begin a designated assessment within 14 days after receiving the request for the assessment, the insured person or the insurer may require that, subject to subsections (1.1), (1.2) and (2), the designated assessment be conducted by another designated assessment centre selected by the Superintendent.

(10.1) The Superintendent may, with the consent of the Minister, delegate in writing to any person the Superintendent's authority to select designated assessment centres under this section.

(11) For the purpose of this section, a designated assessment centre has a conflict of interest relating to a designated assessment if,

(a) the insurer, the insured person or a lawyer or other representative acting on behalf of the insurer or the insured person has a financial interest in the designated assessment centre; or

(b) the designated assessment centre, a related person, an assessor or consultant who will carry out all or part of the designated assessment or a facility owned or controlled, directly or indirectly, in whole or in part, by the centre or a related person,

(i) has provided goods or services to the person to be assessed, other than a previous designated assessment,

(ii) prepared or approved a treatment confirmation form under section 37.1, a treatment plan under section 38 or an application for approval of an assessment or examination under section 38.2 for the person to be assessed, or

(iii) is identified by a treatment confirmation form, treatment plan or an application for approval of an assessment or examination as a person who will provide goods or services to the person to be assessed.

(12) In clause (11) (b),

"related person" means, in respect of a designated assessment centre, an owner, partner or another person who has a financial interest in the designated assessment centre, but does not include a person who has a financial interest in the designated assessment centre by reason only of being a creditor who deals at arm's length with the designated assessment centre.

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Financial Services Commission of Ontario
Commission des services financiers de l'Ontario

PRACTICE NOTE
NOTE PRATIQUE

1

Dispute Resolution Group / Groupe de réglement des differends

THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS

USING MEDICAL EVIDENCE TO SUPPORT YOUR CLAIM FOR ACCIDENT BENEFITS

Note: This Practice Note is currently being revised.

Ontario

Financial Services Commission of Ontario
Commission des services financiers de l'Ontario

PRACTICE NOTE
NOTE PRATIQUE
2

Dispute Resolution Group / Groupe de réglement des differends

THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS

REACHING A SETTLEMENT WITHIN THE DISPUTE RESOLUTION PROCESS

Note: This Practice Note is currently being revised.

LIABILITY

(3) An insurer against whom a person has recourse for the payment of statutory accident benefits is liable to pay the benefits.

CHOICE OF INSURER

(4) If, under subparagraph i or iii of paragraph 1 or subparagraph i or iii of paragraph 2 of subsection (2), a person has recourse against more than one insurer for the payment of statutory accident benefits, the person, in his or her absolute discretion, may decide the insurer from which he or she will claim the benefits.

(5) Despite subsection (4), if a person is a named insured under a contract evidenced by a motor vehicle liability policy or the person is the spouse or same-sex partner or a dependant, as defined in the *Statutory Accident Benefits Schedule*, of a named insured, the person shall claim statutory accident benefits against the insurer under that policy.

SAME

(5.1) Subject to subsection (5.2), if there is more than one insurer against which a person may claim benefits under subsection (5), the person, in his or her discretion, may decide the insurer from which he or she will claim the benefits.

SAME

(5.2) If there is more than one insurer against which a person may claim benefits under subsection (5) and the person was, at the time of the incident, an occupant of an automobile in respect of which the person is the named insured or the spouse or same-sex partner or a dependant of the named insured, the person shall claim statutory accident benefits against the insurer of the automobile in which the person was an occupant.

ONTARIO REGULATION 283/95
DISPUTES BETWEEN INSURERS

1. All disputes as to which insurer is required to pay benefits under section 268 of the Act shall be settled in accordance with this Regulation.

2. The first insurer that receives a completed application for benefits is responsible for paying benefits to an insured person pending the resolution of any dispute as to which insurer is required to pay benefits under section 268 of the Act.

3. (1) No insurer may dispute its obligation to pay benefits under section 268 of the Act unless it gives written notice within 90 days of receipt of a completed application for benefits to every insurer who it claims is required to pay under that section.

(2) An insurer may give notice after the 90-day period if,

(a) 90 days was not a sufficient period of time to make a determination that another insurer or insurers is liable under section 268 of the Act; and

(b) the insurer made the reasonable investigations necessary to determine if another insurer was liable within the 90-day period.

(3) The issue of whether an insurer who has not given notice within 90 days has complied with subsection (2) shall be resolved in an arbitration under section 7.

4. An insurer that gives notice under section 3 shall also give notice to the insured person using a form approved by the Superintendent.

5. (1) An insured person who receives a notice under section 4 shall also advise the insurer paying benefits in writing within 14 days whether he or she objects to the transfer of the claim to the insurers referred to in the notice.

(2) If the insured person does not advise the insurer within 14 days that he or she objects to the transfer of the claim, the insured person is not entitled to object to any subsequent agreement or decision to transfer the claim to the insurers referred to in the notice.

(3) An insured person who has given notice of an objection is entitled to participate as a party in any subsequent proceeding to settle the dispute and no agreement between insurers as to which insurer should pay the claim is binding unless the insured person consents to the agreement or 14 days have passed since the insured person was notified in writing of an agreement and the insured person has not initiated an arbitration under the *Arbitrations Act, 1991*.

Financial Services Commission of Ontario
Commission des services financiers de l'Ontario
Ontario

PRACTICE NOTE
NOTE PRATIQUE
11

Dispute Resolution Group / Groupe de réglement des differends

THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS AND INSURERS

JURISDICTIONAL ISSUES ARISING IN MEDIATION

This Practice Note is to advise claimants and insurers of the policy of the Financial Services Commission of Ontario ("Commission") on jurisdictional issues which frequently arise upon entry to the mediation process.

A. GENERAL JURISDICTION:

Mediation at the Commission helps to resolve disputes concerning benefits available under the various *Statutory Accident Benefits Schedules ("SABS")* passed since June 22, 1990. These benefits are available in respect of personal injuries from motor vehicle accidents. Mediation does not deal with claims that arose out of accidents occurring before June 22, 1990. You may wish to contact the Office of the Insurance Ombudsman at the Commission for information relating to disputes against an insurer that are beyond the mandate of Mediation Services.

1. NO MEDIATION OF CLAIMS FOR PROPERTY DAMAGE

Mediation Services does not accept applications to mediate disputes concerning damage to automobiles or other property except as specifically set out in the *SABS*.

2. NO MEDIATION OF A CLAIM FOR WEEKLY BENEFITS FOR THE FIRST WEEK OF DISABILITY

The *SABS* provide that no weekly benefit is payable for the first week of disability. Mediation Services does not accept applications to mediate a claim for entitlement to a weekly benefit for the first week of disability.

3. NO MEDIATION WHERE A CLAIM FOR ACCIDENT BENEFITS HAS NOT BEEN SUBMITTED TO INSURER

Claimants may use the services of mediation when an accident benefit has been claimed from an automobile insurer and denied. Claimants are entitled to receive written notice from the insurer of a refusal to pay a claim along with an explanation for the refusal. Mediation Services does not accept an ***Application for Mediation*** where the claimant has not first submitted his or her claim to the insurer. Where a claim has been submitted to an insurer and the time specified in the regulation for reviewing the claim by the insurer has expired, Mediation Services will accept the ***Application for Mediation*** on the basis of the insurer's deemed denial.

4. PREVIOUSLY MEDIATED ISSUES

Mediation Services does not re-mediate issues that have been dealt with in a previous mediation and the **Report of Mediator** states that the issue was not resolved. The options after a failed mediation, are:

- take no further steps;
- file an ***Application for Arbitration*** at the Commission;
- appoint a private arbitrator pursuant to the provisions of the *Arbitration Act* and the *Insurance Act*;
- request Neutral Evaluation, privately or through an ***Application for Arbitration*** at the Commission;
- commence a court action.

5. SPECIAL AWARD

Mediation Services does not accept an ***Application for Mediation*** of a claim for a Special Award, as this is not a benefit provided under the *SABS*. A special award is a matter of the exercise of an arbitrator's discretion.

6. LEGAL EXPENSES

Mediation Services does not accept applications to mediate a dispute over legal fees and disbursements, as this is not a benefit provided under the *SABS*.

An award of legal expenses is a hypothetical matter that does not arise until the arbitration or court proceeding is concluded. Therefore, the issue must be addressed as part of the arbitration or court proceeding.

B. EXPIRY OF LIMITATION PERIODS

1. TIME LIMIT TO APPLY TO INSURER FOR ACCIDENT BENEFITS

(i) The *Statutory Accident Benefits Schedules* establish time limits for applying for accident benefits. However, late applications must be accepted if the insured person has a "reasonable excuse" for the delay.

Disputes concerning whether a delay was reasonable will be accepted for mediation. The preliminary issue concerning the reasonableness of the delay will be mediated along with the disputes concerning the statutory accident benefits claimed in the ***Application for Mediation.***

(ii) **Exception.** There is an exception for accidents that occurred on or after June 22, 1990 and before January 1, 1994. The *Schedule* (Bill 68) provides that an injured person must apply to their insurer for accident benefits within two years after the accident. If no claim for accident benefits is made to the insurer within two years, the Commission has no jurisdiction to mediate. However, disputes concerning whether a claim for benefits was made to the insurer within two years will be accepted for mediation. The preliminary issue of whether the limitation period to claim benefits has expired, will be mediated along with the disputes concerning statutory accident benefits claimed in the ***Application for Mediation.***

2. TIME LIMIT TO APPLY TO THE COMMISSION FOR MEDIATION OF DISPUTES OVER BENEFITS

The *SABS* provide that a claimant may commence mediation at the Commission within two years of the insurer's written refusal to pay the benefit claimed. Mediation Services does not accept an ***Application for Mediation*** if it is made to the Commission beyond two years. However, disputes concerning whether an ***Application for Mediation*** was made to the Commission within two years of the insurer's written refusal to pay benefits will be accepted for mediation. The preliminary issue of the expiry of the limitation period will be mediated, along with the disputes concerning statutory accident benefits claimed in the ***Application for Mediation.***

If the limitation period issue arises in the Mediation intake process, the mediation caseworker will notify the claimant of the limitation period and will require the claimant to provide a letter confirming that he or she wishes to dispute the expiration of the time limit. If the issue is raised by the insurer during the mediation process, no letter from the claimant is required.

C. DISPUTES BETWEEN INSURERS – LIABILITY REGULATION 283/95

Mediation Services does not deal with disputes about which of several insurers is required to pay the claimant's *SABS* (See **Practice Note 10,** "Process for Settling Disputes Between Auto Insurance Companies (Reg. 283/95)").

Mediation Services will accept an ***Application for Mediation*** made against the **first insurer** to receive a completed application for accident benefits, concerning the claimant's entitlement to benefits. A mediation caseworker will clarify with the parties which insurer (licensed in Ontario or subject

to Ontario law through an undertaking), first received the completed application for accident benefits.

Disputes concerning which insurer was the first to receive the completed application for *SABS* will be mediated as a preliminary issue, along with the disputes concerning accident benefits claimed in the ***Application for Mediation***.

D. FULL AND FINAL RELEASE – SETTLEMENT REGULATION 664 AS AMENDED BY O.R. 780/93

Mediation Services does not accept an ***Application for Mediation*** where a claimant has signed a valid full and final release of his or her entitlement to *SABS* arising from the motor vehicle accident in question and the insurer has complied with the requirements of the **Settlement Regulation.**

Mediation Services will accept an ***Application for Mediation*** where:

(i) the claimant disputes the validity of the settlement, such as whether the insurer has complied with the requirements of the **Settlement Regulation.**

(ii) a court or private arbitrator has set aside a previous settlement on such grounds as fraud, duress or misrepresentation;

(iii) the parties agree to set aside the settlement;

(iv) the claimant resiles from a settlement within the 48 hour cooling off period in accordance with the **Settlement Regulation** (See **Practice Note 2,** "Reaching a Settlement within the Dispute Resolution Process");

The preliminary issue of the validity of the settlement will be mediated along with the disputes concerning statutory benefits claimed in the ***Application for Mediation.***

Mediation Services will not re-mediate issues that have been dealt with in a previous Commission mediation as reflected in the **Report of Mediator.** The options after a mediation where issues were reported as resolved but the validity of the settlement is now in dispute, are:

- take no further steps
- file an ***Application for Arbitration*** at the Commission
- appoint a private arbitrator pursuant to the provisions of the *Arbitration Act* and the *Insurance Act.*
- request Neutral Evaluation, privately or through the Commission
- commence a court action.

E. APPLICATION FOR A NON-EARNER BENEFIT SUBMITTED TO THE INSURER PRIOR TO 26 WEEKS

For accidents occurring on or after November 1, 1996 (Bill 59), a claimant may be eligible to receive a Non-Earner Benefit, 26 weeks after the onset of disability. Mediation Services does not accept applications to mediate the issue of entitlement to a Non-Earner Benefit prior to the expiry of the 26 week period.

HOW DO I GET MORE INFORMATION?

The Commission telephone numbers are:

From Toronto, call: (416) 250-6714
From outside Toronto, phone: 1-800-517-2332

To reach the Office of the Insurance Ombudsman at the Commission, the telephone numbers are:

From Toronto, call (416) 250-7250
From outside Toronto, phone 1-800-668-0128

Cette publication est Également disponible en français

Financial Services Commission of Ontario
Commission des services financiers de l'Ontario
Ontario

PRACTICE NOTE
NOTE PRATIQUE
12

Dispute Resolution Group / Groupe de réglement des differends

THIS PRACTICE NOTE IS INTENDED FOR USE BY CLAIMANTS

WHAT CLAIMANTS NEED TO KNOW ABOUT DESIGNATED ASSESSMENT CENTRES

WHAT IS THE DESIGNATED ASSESSMENT CENTRE (DAC) SYSTEM?

DACs were set up throughout Ontario in 1994 to provide unbiased opinions about the injuries of car accident victims and the care or treatment they may need.

Each DAC must be approved by the Minister's Committee on the DAC System (DAC Committee), which is appointed by the Minister of Finance and includes consumers, health care professionals, insurance company representatives and lawyers. The DAC Committee issues Guidelines to assist DACs in writing reports that are fair and based on the most up-to-date information.

There are five types of DAC assessments:

- Disability
- Medical and Rehabilitation
- Attendant Care
- Catastrophic Impairment [For accidents on or After November 1, 1996]
- Residual Earning Capacity [For accidents between January 1, 1994 and October 31, 1996]

The health care professionals at each DAC are only authorized to perform the types of assessments for which the DAC has been approved. Some DACs perform more than one type of assessment. If you and your insurer are involved in a dispute over more than one issue, you may have to attend more than one assessment. Sometimes the separate assessments can be done by one DAC at the same time.

WHAT DETERMINES WHICH DACS MAY DO THE ASSESSMENT?

Ontario insurance law outlines which DACs may do the assessment:

- The DAC must be authorized to conduct the type of assessment that is required in your case.
- If you live within the Greater Toronto Area (the City of Toronto and the regional municipalities of Durham, Halton, Peel and York), the assessment must be conducted by a DAC located within 30 kilometres of your home.
- In all other areas of Ontario, the assessment must be conducted by a DAC located within 50 kilometres of your home.

There may be any number of DACs in your area that are able to conduct the assessment. Your insurance company will provide you with a list of DACs that meet the selection criteria.

If you wish to review the list of DACs, the full roster of DACs can be found on FSCO's website at **www.fsco.gov.on.ca** (Click on Insurance, then Designated Assessment Centres).

HOW DO WE JOINTLY SELECT A DAC?

Once the need for a DAC assessment has been identified, you and your insurer have two business days to try to agree on a DAC to conduct the assessment.

Those two business days begin to run on the day after either one of you receives notice from the other that a DAC assessment is needed.

There are no restrictions on which DAC you and your insurer agree on, other than those outlined above under *What determines which DAC may do the assessment?*.

If an agreement on a DAC is reached, it is the responsibility of your insurer to refer your file to the DAC to begin the assessment process.

What happens if we are unable to jointly select a DAC?

If you and your insurer are unable to jointly select a qualifying DAC within two business days, your insurance company must ask FSCO to select a DAC to conduct the assessment.

Under FSCO's selection process, a DAC will be selected from the roster of qualifying DACs.

The DAC selected by FSCO may not be the DAC closest to your home. Also, neither you nor your insurer will be able to ask for another selection unless the DAC selected by FSCO is not able to conduct the required assessment (i.e. Conflict of interest or inability to meet required timelines).

Once FSCO has selected a DAC, you will be notified by the insurer and the insurer will then send the necessary information to the DAC to begin the assessment process.

What information should be sent to the DAC?

The **Designated Assessment Referral Plan and Summary Form (OCF-11)** is to be completed by the insurer. The OCF-11 requires the insurer to indicate the type of assessment to be conducted and specifics regarding the issues in dispute.

All of the information forwarded by the insurer to the DAC will form part of the assessment. The insurer is required to send copies of the OCF-11A to the DAC and to you.

When you receive your copy of the OCF-11, you should review the list of documents sent to the DAC. It is your responsibility to provide the DAC with any other documents, such as recent test results, which may be useful in completing the assessment.

With more complete information, the DAC will be able to conduct a better assessment and help resolve the issue in dispute.

What if the DAC requests more information?

There may be cases where, in the opinion of the DAC, important information is missing. The DAC may then ask you or your insurer to provide the missing information, and advise that the assessment could be delayed depending on what information is missing.

If the DAC can get this missing information more quickly on its own, the DAC may gather the information directly, provided that it does so with your permission.

What happens after you have been assessed at a DAC?

After the DAC has looked at the case, the DAC will write a report explaining *clearly* how the assessment was conducted, the results of the assessment, and what the DAC concludes about your case *and the reasons* for its opinion.

A final, written report will be produced at the end of an assessment. No final written report can be produced if parts of the assessment have yet to be completed. The DAC will provide you and your insurer with written reasons why the assessment was not completed, and confirm that no final report will be produced until the entire assessment is completed.

Please note that the only time a DAC is permitted to issue an addition to a DAC report is to clarify the DAC findings, to correct an error in the original DAC report, or to deal with something missing in the DAC report.

If new information emerges and the parties agree that the review of the *new* material may change the DAC's opinion, then a new DAC assessment should be arranged. Neither party should request an "updated" report from the DAC.

Where the parties disagree with either the report of the DAC or the impact of any new information on the original DAC findings, either party may choose to apply for mediation with the Dispute Resolution Services Branch of the Financial Services Commission of Ontario.

WHAT DO YOU DO IF YOU HAVE A COMPLAINT ABOUT A DAC?

The DAC Committee has established a process to deal with complaints regarding DACs which fail to conduct assessments as set out in the procedures and guidelines issued by the DAC Committee.

The DAC Committee cannot review complaints which fall outside its control, including complaints relating to the business practices of an insurer, the professional conduct of a health care provider or complaints concerning the conclusions in a DAC Report.

HOW CAN I GET MORE INFORMATION?

If you have any questions regarding the DAC System and the assessment process, you may direct your questions to:

The Automobile Insurance Policy Unit
Financial Services Commission of Ontario
5160 Yonge Street, Box 85
Toronto ON M2N 6L9

You may also call the DAC hotline at 416-590-7137 or 1-800-668-0128, extension 7137.

If you want copies of any published DAC material including an up-to-date roster of DACs, please visit FSCO's website at **www.fsco.gov.on.ca** (Click on Insurance, then Designated Assessment Centres).

SECTION E – SETTLEMENT REGULATION

THE SETTLEMENT REGULATION

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SETTLEMENT FORMS

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FOR SETTLEMENTS MADE ON OR AFTER MARCH 1, 2002

EXCERPT FROM R.R.O. 1990, REG. 664, AS AMENDED BY O. REG. 275/03.

SETTLEMENTS - STATUTORY ACCIDENT BENEFITS

9.1 (1) In this section, "settlement" means an agreement between an insurer and an insured person that finally disposes of a claim or dispute in respect of the insured person's entitlement to one or more benefits under the *Statutory Accident Benefits Schedule*.

(2) The insurer shall give the insured person a written disclosure notice, signed by the insurer, with respect to the settlement.

(3) The disclosure notice shall be in a form approved by the Superintendent and shall contain the following information:

1. The insurer's offer with respect to the settlement.

2. A description of the benefits that may be available to the insured person under the *Statutory Accident Benefits Schedule*.

3. A statement that the insured person may, within two business days after the later of the day the insured person signs the disclosure notice and the day the insured person signs the release, rescind the settlement by delivering a written notice to the office of the insurer or its representative and returning any money received by the insured person as consideration for the settlement.

4. A description of the consequences of the settlement on the benefits described under paragraph 2 including,

   i. a statement of the restrictions contained in the settlement on the insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order under sections 280 to 284 of the Act, and

   ii. a statement that the tax implications of the settlement may be different from the tax implications of the benefits described under paragraph 2.

5. A statement advising the insured person to consider seeking independent legal, financial and medical advice before entering into the settlement.

6. A statement for signature by the insured person acknowledging that he or she has read the disclosure notice and considered seeking independent legal, financial and medical advice before entering into the settlement.

(4) The insured person may rescind the settlement within two business days after the later of the day the insured person signs the disclosure notice and the day the insured person signs the release.

(5) The insured person may rescind the settlement after the period referred to in subsection (4) if the insurer has not compiled with subsections (2) and (3).

(6) Subsections (4) and (5) do not apply with respect to a settlement that has been approved by a court under Rule 7 of the Rules of Civil Procedure (Parties under Disability).

(7) The insured person shall rescind a settlement under subsection (4) or (5) by delivering a written notice to the office of the insurer or its representative and returning any money received by the insured person as consideration for the settlement.

(8) No person may commence a mediation proceeding under section 280 of the Act with respect to benefits that were the subject of a settlement or a purported settlement unless the person has returned the money received as consideration for the settlement.

(9) If the insured person returns money to the insurer under subsection (7) or (8) and a dispute arises between the insurer and the insured person with respect to the validity of the purported settlement or the right of the insured person to rescind the settlement, the insurer shall hold the money in trust until the matter is determined, at which time the amount and any income on the amount,

(a) shall be paid to the insured, if it is determined or agreed that there was a valid settlement that was not rescinded; and

(b) shall be returned to the insurer, if it is determined or agreed that there was no settlement, or that the settlement was invalid or was rescinded.

(10) A restriction on an insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order under sections 280 to 284 of the Act is not void under subsection 279 (2) of the Act if,

(a) the restriction is contained in a settlement;

(b) the settlement is entered into on or after the first anniversary of the day of the accident that gave rise to the claim; and

(c) the insurer complied with subsections (2) and (3).

(11) Despite clause (10) (b), a restriction contained in a settlement entered into before the first anniversary of the day of the accident that gave rise to the claim is not void under subsection 279 (2) of the Act if, in respect of the claim,

(a) the insured person brought a proceeding in a court of competent jurisdiction under clause 281 (1) (a) of the Act and examinations for discovery have commenced;

(b) the insured person referred the issues in dispute to an arbitrator under clause 281 (1) (b) of the Act and a pre-hearing conference has been completed; or

(c) the insurer and the insured agreed under clause 281 (1) (c) of the Act to submit the issues in dispute for arbitration in accordance with the *Arbitration Act, 1991* and an arbitration agreement under that Act has been entered into.

(12) Clause (10) (b) and subsection (11) apply to claims that have not settled before October 1, 2003, unless a disclosure notice under subsection (2) in respect of the settlement or purported settlement was given to the insured person before that date.

FOR SETTLEMENTS MADE BEFORE MARCH 1, 2002

EXCERPT FROM R.R.O. 1990, O. REG. 664, AS AMENDED BY O. REG. 780/93.

SETTLEMENTS - STATUTORY ACCIDENT BENEFITS

9.1 (1) In this section, "settlement" means an agreement between an insurer and an insured person that finally disposes of a claim or dispute in respect of the insured person's entitlement to one or more benefits under the *Statutory Accident Benefits Schedule*.

(2) Before a settlement is entered into between an insurer and an insured person, the insurer shall give the insured person a written notice that contains the following:

1. A description of the benefits that may be available to the insured person under the *Statutory Accident Benefits Schedule* and any other benefits that may be available to the insured person under a contract of automobile insurance.

2. A description of the impact of the settlement on the benefits described under paragraph 1, including a statement of the restrictions contained in the settlement on the insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order as provided in sections 280 to 284 of the Act.

3. A statement that the insured person may rescind the settlement within two business days after the settlement is entered into by delivering a written notice to the insurer.

4. A statement that the tax implications of the settlement may be different from the tax implications of the benefits described under paragraph 1.

5. If the settlement provides for the payment of a lump sum in an amount offered by the insurer and, with respect to a benefit under the Statutory Accident Benefits Schedule that is not a lump sum benefit, the settlement contains a restriction on the insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order as provided in sections 280 to 284 of the Act, a statement of the insurer's estimate of the commuted value of the benefit and an explanation of how the insurer determined the commuted value.

6. A statement advising the insured person to consider seeking independent legal, financial and medical advice before entering into the settlement.

(3) A settlement may be rescinded by the insured person, within two business days after the settlement is entered into, by delivering a written notice to the insurer.

(4) If the insurer did not comply with subsection (2), the insured person may rescind the settlement after the period mentioned in subsection (3) by delivering a written notice to the insurer.

(5) A restriction on an insured person's right to mediate, litigate, arbitrate, appeal or apply to vary an order as provided in sections 280 to 284 of the Act is not void under subsection 279(2) of the Act if,

(a) the restriction is contained in a settlement; and

(b) the insurer complied with subsection (2). O.Reg.780/93, s.7.

SETTLEMENT DISCLOSURE NOTICE

FINAL SETTLEMENT OF A STATUTORY ACCIDENT BENEFITS CLAIM
BILL 59

(For accidents on or after November 1, 1996)

NOTICE AND CAUTION

Your insurer is required to give you this SETTLEMENT DISCLOSURE NOTICE if you have both agreed on a cash settlement that will permanently end your entitlement to one or more accident benefits. This SETTLEMENT DISCLOSURE NOTICE must be completed and signed by your insurer. Your insurer will probably also give you a Release to sign.

- YOU CANNOT ENTER INTO A CASH SETTLEMENT WITHIN A YEAR FROM THE DATE OF THE ACCIDENT, WITH SOME EXCEPTIONS.[1]
- YOU SHOULD CONSIDER SEEKING LEGAL, FINANCIAL AND MEDICAL ADVICE BEFORE YOU SIGN A RELEASE.
- IF YOU SIGN THIS SETTLEMENT DISCLOSURE NOTICE AND A RELEASE, YOU WILL BE GIVING UP RIGHTS YOU MAY HAVE NOW OR IN FUTURE, EVEN IF YOUR CONDITION CHANGES.
- IF YOU CHOOSE NOT TO SIGN, YOUR BENEFITS WILL NOT BE AFFECTED OR REDUCED.
- IF YOU DO SIGN THIS NOTICE AND A RELEASE YOU HAVE 2 BUSINESS DAYS TO CHANGE YOUR MIND.
- YOU HAVE THE RIGHT TO SEEK ANY MEDICAL INFORMATION RELATING TO YOUR CLAIM IN YOUR INSURER'S FILE AND TO OBTAIN A COPY AT THE INSURER'S EXPENSE. IF YOU WANT TO SEE THIS INFORMATION, ASK YOUR INSURER FOR A COPY.

PLEASE READ THIS ENTIRE DOCUMENT CAREFULLY

[1] You may enter into a cash settlement within a year from the date of the accident if within the same period you brought a lawsuit and commenced discovery; or you referred the dispute to an arbitrator at the Financial Services Commission of Ontario and completed a pre-hearing conference; or you and your insurer agreed to a private arbitration and entered into an arbitration agreement.

INSURER'S OFFER TO SETTLE BENEFITS

OFFER TO SETTLE INCOME REPLACEMENT BENEFITS

You have been offered $ _____ for all past and future income replacement benefits.

OFFER TO SETTLE NON-EARNER BENEFITS

You have been offered $ _____ for all past and future non-earner benefits.

OFFER TO SETTLE CAREGIVER BENEFITS

You have been offered $ _____ for all past and future caregiver benefits.

OFFER TO SETTLE MEDICAL BENEFITS

You have been offered $ _____ for all past and future medical benefits.

OFFER TO SETTLE REHABILITATION BENEFITS

You have been offered $ _____ for all past and future rehabilitation benefits.

OFFER TO SETTLE ATTENDANT CARE BENEFITS

You have been offered $ _____ for all past and future attendant care benefits.

OFFER TO SETTLE DEATH AND FUNERAL BENEFITS

You have been offered $ _____ for all past and future death benefits and funeral benefits.

OFFER TO SETTLE BENEFITS FOR PAYMENT OF OTHER EXPENSES (specify)

_____

You have been offered $ _____ for all past and future benefits for other expenses.

OFFER TO SETTLE ANY OTHER ITEMS (specify) _____

You have been offered $ _____ for other items.

TOTAL OFFER $ _____

Provide any other details:

WHAT DOES IT MEAN IF YOU SETTLE YOUR CLAIM?

THERE ARE A NUMBER OF CONSEQUENCES OF THIS SETTLEMENT IF YOU SIGN THIS NOTICE AND A RELEASE:

- You are finally and permanently settling your claim for the benefits specified. You are forever giving up the right to claim such benefits in the future, even if your medical problems get worse.
- You are permanently giving up your right under the *Insurance Act* to mediate, litigate, arbitrate, appeal, apply to vary, or to proceed to judicial review by a court, concerning the benefits which are the subject of the settlement.
- The tax implications of the settlement may be different than the tax implications of the benefits described. In general, any investment income earned on the cash amount of the settlement may be subject to tax.

Example

If you are entitled to receive weekly income benefits, and agree to settle your claim for $20,000.00 which you then invest, any interest income you receive will likely be taxable. If you choose to receive weekly income benefits instead of a settlement, your weekly benefits will probably not be taxable.

YOU ARE ADVISED TO CONSIDER SEEKING LEGAL, FINANCIAL AND MEDICAL ADVICE BEFORE ENTERING INTO ANY SETTLEMENT. IT IS ESPECIALLY IMPORTANT TO SEEK ADVICE IF YOUR IMPAIRMENT IS "CATASTROPHIC"*.

***What is a "catastrophic impairment"?**

"Catastrophic impairment" includes: paraplegia or quadriplegia, amputation or other impairment causing total and permanent loss of use of both arms or total and permanent loss of both an arm and leg or both legs, total loss of vision, certain brain injuries, significant or extreme mental and behavioural disorders, and certain other combinations of impairments that result in 55% or more impairment of the whole person. A determination must be made by medical experts. If you feel your injuries may be catastrophic, you should contact your medical and legal advisors. **If your impairment is catastrophic, the amount of medical, rehabilitation and attendant care benefits available to you changes significantly (see "Description of Benefits").**

DESCRIPTION OF BENEFITS

THE DETAILS OF THE BENEFITS AND YOUR RIGHTS AND RESPONSIBILITIES ARE IN THE *STATUTORY ACCIDENT BENEFITS SCHEDULE* OF THE *INSURANCE ACT* (ONTARIO). YOUR INSURANCE COMPANY IS OBLIGATED TO GIVE YOU INFORMATION ABOUT THE BENEFITS AVAILABLE.

The benefits provided under the *Statutory Accident Benefits Schedule* are complex and extensive. A short description of these benefits is provided below.

Income Replacement Benefits

This benefit compensates for lost income if you are unable to perform the essential tasks of the job you did before the accident. The benefit is 80% of your net income before the accident. The maximum benefit is $400 per week. However, if you are covered by optional weekly income replacement benefits, the maximum benefit may be $600, $800, or $1,000 per week.

Non-Earner Benefit

This benefit compensates you if you are completely unable to carry on a normal life, and do not qualify for an Income Replacement Benefit or Caregiver Benefit. The benefit is $185 per week, but may be $320 per week if you were a student or recent graduate. The benefit begins twenty-six weeks after you become completely unable to carry on a normal life.

Caregiver Benefits

This benefit compensates you for expenses incurred if you cannot continue as the main caregiver for a person in your household such as child under age 16 or other person who needs care. The benefit pays expenses up to $250 per week, but if you provide care for more than one person, the limit is increased by $50 for each additional person. If you are covered by optional caregiver benefits, the benefit pays expenses up to $325 per week and $75 per week for each additional person.

Medical Benefit

This benefit pays for medical expenses incurred as a result of your injuries. These are expenses that are not covered by any other medical plan, such as the Ontario Health Plan, or any medical plans at the workplace.

Rehabilitation Benefit

This benefit pays for some rehabilitation expenses incurred as a result of your injuries. These are expenses that are not covered by any other plan.

Attendant Care Benefit

This benefit compensates for the expense of an aide or attendant or services provided by a long-term care facility.

Maximum Medical, Rehabilitation and Attendant Care Benefits

The maximum amount paid for medical and rehabilitation expenses combined is $100,000, with a 10 year time limit, and $72,000 for attendant care benefits with a two year time limit. If your impairment is catastrophic, the maximum amount is $1,000,000 for medical and rehabilitation expenses, and $1,000,000 for attendant care expenses, with no time limits. If you are covered by optional medical, rehabilitation and attendant care benefits, an additional $1,000,000 above the basic benefits is available.

Payment of Other Expenses

This benefit pays for some other expenses such as the expenses of family members in visiting you during treatment or recovery. It also pays for some housekeeping and home maintenance; the repair or replacement of items lost or damaged in the accident such as clothing, prescription eyewear, dentures, hearing aids, prostheses and medical or dental devices; and lost educational expenses. This benefit also covers the reasonable cost of examinations obtained for the purposes of the *Statutory Accident Benefits Schedule*.

Death Benefits

This benefit pays family members of a person killed in an automobile accident. $25,000 is paid to a surviving spouse, $10,000 to each surviving dependant, and a total of $10,000 to a person in respect of whom the deceased was a dependant. The amounts are doubled if you are covered by optional benefits.

Funeral Expenses

This benefit pays up to $6,000 to cover funeral expenses. The maximum amount is $8,000 if you are covered by optional benefits.

Optional Benefits

Optional benefits increase the amount of basic benefits. They must be purchased before the accident. The optional benefits are: Increased Income Replacement; Increased Caregiver and Dependant Care; Increased Medical, Rehabilitation and Attendant Care; Increased Death and Funeral, and Optional Indexation Benefit. **You should consult your insurer and your advisors to determine if you are covered by Optional Benefits.**

INSURER'S DISCLOSURE AND ACKNOWLEDGMENT

The insurer acknowledges that it has made available for review by the insured person or the insured person's representative all medical reports, medical records and other information of a medical nature in the insurer's file relating to the insured person.

I certify the information provided in this Notice is complete and correct.

Representative of insurer _____

Telephone number _____

Name of Insurance Company
Ombudsman Liaison Officer* _____

Telephone number _____

*If you have a complaint about your claim, you may contact your insurer's Ombudsman Liaison Officer who will review and attempt to resolve it with you.

Date _____

INSURED'S ACKNOWLEDGMENT

I acknowledge that I have received and read the above Settlement Disclosure Notice provided to me by an insurer, and have considered whether or not to obtain legal, financial and medical advice.

_____ Date _____

Signature of Insured

IF YOU CHANGE YOUR MIND

IF YOU CHANGE YOUR MIND AFTER AGREEING TO SETTLE YOUR CLAIM BY SIGNING A RELEASE, YOU MUST:

NOTIFY THE INSURER IN WRITING AND RETURN ANY SETTLEMENT FUNDS YOU RECEIVED WITHIN 2 BUSINESS DAYS AFTER YOU SIGNED THE RELEASE

IF YOU SIGNED A RELEASE AND LATER SIGNED THIS DISCLOSURE NOTICE, YOU HAVE 2 BUSINESS DAYS FROM WHEN YOU SIGNED THE DISCLOSURE NOTICE IN WHICH TO NOTIFY THE INSURER AND RETURN ANY SETTLEMENT FUNDS YOU RECEIVED.

Form SDN-198 (10/03)

SETTLEMENT DISCLOSURE NOTICE

FINAL SETTLEMENT OF A STATUTORY ACCIDENT BENEFITS CLAIM BILL 164

(For accidents between January 1, 1994 and October 31, 1996)

NOTICE AND CAUTION

Your insurer is required to give you this SETTLEMENT DISCLOSURE NOTICE if you have both agreed on a cash settlement that will permanently end your entitlement to one or more accident benefits. This SETTLEMENT DISCLOSURE NOTICE must be completed and signed by your insurer. Your insurer will probably also give you a Release to sign.

- YOU SHOULD CONSIDER SEEKING LEGAL, FINANCIAL AND MEDICAL ADVICE BEFORE YOU SIGN A RELEASE.
- IF YOU SIGN THIS SETTLEMENT DISCLOSURE NOTICE AND A RELEASE, YOU WILL BE GIVING UP RIGHTS YOU MAY HAVE NOW OR IN FUTURE, EVEN IF YOUR CONDITION CHANGES.
- IF YOU CHOOSE NOT TO SIGN, YOUR BENEFITS WILL NOT BE AFFECTED OR REDUCED.
- IF YOU DO SIGN THIS NOTICE AND A RELEASE YOU HAVE 2 BUSINESS DAYS TO CHANGE YOUR MIND.
- YOU HAVE THE RIGHT TO SEE ANY MEDICAL INFORMATION RELATING TO YOUR CLAIM IN YOUR INSURER'S FILE AND TO OBTAIN A COPY AT THE INSURER'S EXPENSE. IF YOU WANT TO SEE THIS INFORMATION, ASK YOUR INSURER FOR A COPY.

PLEASE READ THIS ENTIRE DOCUMENT CAREFULLY

INSURER'S OFFER TO SETTLE BENEFITS

OFFER TO SETTLE INCOME REPLACEMENT BENEFITS

You have been offered $ _____ for all past and future income replacement benefits.

OFFER TO SETTLE EDUCATION DISABILITY BENEFITS

You have been offered $ _____ for all past and future weekly education disability benefits if no income.

You have been offered $ _____ for all past and future lump sum education disability benefits.

OFFER TO SETTLE CAREGIVER BENEFITS

You have been offered $ _____ for all past and future caregiver benefits benefits.

OFFER TO SETTLE OTHER DISABILITY BENEFITS

You have been offered $ _____ for all past and future other disability benefits.

OFFER TO SETTLE LOSS OF EARNING CAPACITY BENEFITS

You have been offered $ _____ for all past and future loss of earning capacity benefits.

OFFER TO SETTLE SUPPLEMENTARY MEDICAL BENEFITS

You have been offered $ _____ for all past and future supplementary medical benefits.

OFFER TO SETTLE REHABILITATION BENEFITS

You have been offered $ _____ for all past and future rehabilitation benefits.

OFFER TO SETTLE ATTENDANT CARE BENEFITS

You have been offered $ _____ for all past and future attendant care benefits.

OFFER TO SETTLE DEATH BENEFITS

You have been offered $ _____ for all past and future death benefits.

OFFER TO SETTLE FUNERAL BENEFITS

You have been offered $ _____ for all past and future funeral benefits.

Form SDN-164 (03/03)

INSURER'S OFFER TO SETTLE BENEFITS

OFFER TO SETTLE BENEFITS FOR OTHER PECUNIARY LOSSES (specify)

You have been offered $ _____ for all past and future benefits for compensation for other pecuniary losses.

OFFER TO SETTLE ANY OTHER ITEMS (specify)

_____

You have been offered $ _____ for other items.

TOTAL OFFER $_____

Provide any other details:

WHAT DOES IT MEAN IF YOU SETTLE YOUR CLAIM?

THERE ARE A NUMBER OF CONSEQUENCES OF THIS SETTLEMENT IF YOU SIGN THIS NOTICE AND A RELEASE:

- You are finally and permanently settling your claim for the benefits specified. You are forever giving up the right to claim such benefits in the future, even if your medical problems get worse.
- You are permanently giving up your right under the *Insurance Act* to mediate, litigate, arbitrate, appeal, apply to vary, or to proceed to judicial review by a court, concerning the benefits which are the subject of the settlement.
- The tax implications of the settlement may be different than the tax implications of the benefits described. In general, any investment income earned on the cash amount of the settlement may be subject to tax.

Example

If you are entitled to receive weekly income benefits, and agree to settle your claim for $20,000.00 which you then invest, any interest income you receive will likely be taxable. If you choose to receive weekly income benefits instead of a settlement, your weekly benefits will probably not be taxable.

YOU ARE ADVISED TO CONSIDER SEEKING LEGAL, FINANCIAL AND MEDICAL ADVICE BEFORE ENTERING INTO ANY SETTLEMENT.

DESCRIPTION OF BENEFITS

THE DETAILS OF THE BENEFITS AND YOUR RIGHTS AND RESPONSIBILITIES ARE IN THE *STATUTORY ACCIDENT BENEFITS SCHEDULE* OF THE *INSURANCE ACT* (ONTARIO). YOUR INSURANCE COMPANY IS OBLIGATED TO GIVE YOU INFORMATION ABOUT THE BENEFITS AVAILABLE.

The benefits provided under the *Statutory Accident Benefits Schedule* are complex and extensive. A short description of these benefits is provided below.

Income Replacement Benefits
This benefit compensates you for lost income if you are unable to perform the essential tasks of the job you did before the accident. You may qualify if you were employed or self employed at any point in the previous 3 years before the accident, were on strike, locked out, on lay-off, parental or pregnancy leave, or had a contract to start work within one year. The benefit is 90% of your net income before the accident and is indexed yearly for inflation. The maximum benefit will depend on the year of the accident and duration of your disability. There is a minimum benefit of $185 per week, unindexed.

Education Disability Benefits
Weekly Benefit: This weekly benefit is payable after age 16 if you are a full time student and unable to continue your education, or are unable to carry on a normal life. The amount of weekly education disability benefits is 50% of net Ontario Average Weekly Earnings, and the benefit is indexed yearly.

Lump Sum Benefit: This benefit provides a lump sum payment for each year of school missed, if you are unable to attend or successfully complete one or more school years, or one or more semesters of school that is organized on a semester basis. The maximum lump sum payable is indexed yearly.

Caregiver Benefits
This benefit compensates you if you are the main caregiver for a person in your household such as a child under age 16 or other person who needs care, and you are unable to perform your usual caregiving activities or you suffer a partial or complete inability to lead a normal life. The maximum amount of caregiver benefits is indexed yearly.

Other Disability Benefits
This benefits compensates you if you suffer a partial or complete inability to lead a normal life and you do not qualify for any other weekly benefits. The benefit is $185 per week, unindexed.

Loss of Earning Capacity Benefits
This long-term benefit compensates you if you continue to qualify for weekly benefits more than 104 weeks after you first became disabled. It replaces income replacement benefits, weekly caregiver benefits, weekly education benefits, or other disability benefits, and is based on the difference between pre-accident and post-accident earning capacity.

Supplementary Medical Benefits
This benefit pays for medical expenses incurred as a result of your injuries. These are expenses that are not covered by any other medical plan, such as the Ontario Health Plan, or any medical plans at the workplace.

Rehabilitation Benefits
This benefit pays for rehabilitation expenses incurred as a result of your injuries. These are expenses that are not covered by any other medical plan, such as the Ontario Health Plan, or any medical plans at the workplace.

Maximum Supplementary Medical and Rehabilitation Benefits
There is a lifetime maximum limit of $1,000,000 for supplementary medical and rehabilitation benefits combined. This limit is indexed yearly. The maximum benefit will depend on the year of the accident.

Attendant Care Benefits
This benefit compensates for the expense of an aide or attendant, or services provided by a long-term care facility. There is a monthly limit of $3,000 and no lifetime limit. For certain injuries, the monthly limit may be $6,000 or $10,000 per month. These limits are indexed yearly.

Death Benefits
This benefit pays family members of a person killed in an automobile accident. The maximum amount of the benefit paid to a surviving spouse is based on the income of the deceased person according to a formula: 187.2 x the net weekly income of the deceased. A lump sum is also paid to any dependant of the deceased. If the deceased was a dependant of someone else, such as a parent or other caregiver, a lump sum is paid to that person.

Funeral Expenses
This benefit pays funeral expenses for a person killed in an automobile accident. The maximum amount of the benefit is indexed yearly.

Compensation for Other Pecuniary Losses
This benefit pays for some other expenses such as the expenses of family members in visiting you during treatment or recovery. It also pays additional dependent care expenses for persons receiving income replacement benefits; some housekeeping and home maintenance; and the repair or replacement of items lost or damaged in the accident such as clothing, personal items, dentures, hearing aids, prostheses and medical or dental devices. This benefit also covers the reasonable cost of examinations obtained for the purposes of the *Statutory Accident Benefits Schedule*.

INSURER'S DISCLOSURE AND ACKNOWLEDGMENT

The insurer acknowledges that it has made available for review by the insured person or the insured person's representative all medical reports, medical records and other information of a medical nature in the insurer's file relating to the insured person.

I certify the information provided in this Notice is complete and correct.

Representative of insurer _____

Telephone number _____

Name of Insurance Company
Ombudsman Liaison Officer* _____

Telephone number _____

*If you have a complaint about your claim, you may contact your insurer's Ombudsman Liaison Officer who will review and attempt to resolve it with you.

Date _____

INSURED'S ACKNOWLEDGMENT

I acknowledge that I have received and read the above Settlement Disclosure Notice provided to me by an insurer, and have considered whether or not to obtain legal, financial and medical advice.

_____ Date _____

Signature of Insured

IF YOU CHANGE YOUR MIND

IF YOU CHANGE YOUR MIND AFTER AGREEING TO SETTLE YOUR CLAIM BY SIGNING A RELEASE, YOU MUST:

NOTIFY THE INSURER IN WRITING AND RETURN ANY SETTLEMENT FUNDS YOU RECEIVED WITHIN 2 BUSINESS DAYS AFTER YOU SIGNED THE RELEASE

IF YOU SIGNED A RELEASE AND LATER SIGNED THIS DISCLOSURE NOTICE, YOU HAVE 2 BUSINESS DAYS FROM WHEN YOU SIGNED THE DISCLOSURE NOTICE IN WHICH TO NOTIFY THE INSURER AND RETURN ANY SETTLEMENT FUNDS YOU RECEIVED.

Form SDN-164 (03/03)

SETTLEMENT DISCLOSURE NOTICE

FINAL SETTLEMENT OF A STATUTORY ACCIDENT BENEFITS CLAIM BILL 68

(For accidents between June 22, 1990 and December 31, 1993)

NOTICE AND CAUTION

Your insurer is required to give you this SETTLEMENT DISCLOSURE NOTICE if you have both agreed on a cash settlement that will permanently end your entitlement to one or more accident benefits. This SETTLEMENT DISCLOSURE NOTICE must be completed and signed by your insurer. Your insurer will probably also give you a Release to sign.

- YOU SHOULD CONSIDER SEEKING LEGAL, FINANCIAL AND MEDICAL ADVICE BEFORE YOU SIGN A RELEASE.
- IF YOU SIGN THIS SETTLEMENT DISCLOSURE NOTICE AND A RELEASE, YOU WILL BE GIVING UP RIGHTS YOU MAY HAVE NOW OR IN FUTURE, EVEN IF YOUR CONDITION CHANGES.
- IF YOU CHOOSE NOT TO SIGN, YOUR BENEFITS WILL NOT BE AFFECTED OR REDUCED.
- IF YOU DO SIGN THIS NOTICE AND A RELEASE YOU HAVE 2 BUSINESS DAYS TO CHANGE YOUR MIND.
- YOU HAVE THE RIGHT TO SEE ANY MEDICAL INFORMATION RELATING TO YOUR CLAIM IN YOUR INSURER'S FILE AND TO OBTAIN A COPY AT THE INSURER'S EXPENSE. IF YOU WANT TO SEE THIS INFORMATION, ASK YOUR INSURER FOR A COPY.

PLEASE READ THIS ENTIRE DOCUMENT CAREFULLY

INSURER'S OFFER TO SETTLE BENEFITS

OFFER TO SETTLE WEEKLY INCOME BENEFITS

You have been offered $ _____ for all past and future weekly income benefits.

OFFER TO SETTLE WEEKLY BENEFITS IF NO INCOME

You have been offered $ _____ for all past and future weekly benefits if no income.

OFFER TO SETTLE SUPPLEMENTARY MEDICAL AND REHABILITATION BENEFITS

You have been offered $ _____ for all past and future supplementary medical and rehabilitation benefits.

OFFER TO SETTLE CARE BENEFITS

You have been offered $ _____ for all past and future care benefits.

OFFER TO SETTLE BENEFITS FOR DAMAGE TO CLOTHING, GLASSES, HEARING AIDS AND OTHER DEVICES

You have been offered $ _____ for all past and future damage to clothing, glasses, hearing aids and other devices.

OFFER TO SETTLE FUNERAL EXPENSES

You have been offered $ _____ for all past and future funeral expenses.

OFFER TO SETTLE DEATH BENEFITS

You have been offered $ _____ for all past and future death benefits.

OFFER TO SETTLE ANY OTHER ITEMS (specify) _____

You have been offered $ _____ for other items.

TOTAL OFFER $ _____

Provide any other details:

Form SDN-68 (03/03)

WHAT DOES IT MEAN IF YOU SETTLE YOUR CLAIM?

THERE ARE A NUMBER OF CONSEQUENCES OF THIS SETTLEMENT IF YOU SIGN THIS NOTICE AND A RELEASE:

- You are finally and permanently settling your claim for the benefits specified. You are forever giving up the right to claim such benefits in the future, even if your medical problems get worse.
- You are permanently giving up your right under the *Insurance Act* to mediate, litigate, arbitrate, appeal, apply to vary, or to proceed to judicial review by a court, concerning the benefits which are the subject of the settlement.
- The tax implications of the settlement may be different than the tax implications of the benefits described. In general, any investment income earned on the cash amount of the settlement may be subject to tax.

Example

If you are entitled to receive weekly income benefits, and agree to settle your claim for $20,000.00 which you then invest, any interest income you receive will likely be taxable. If you choose to receive weekly income benefits instead of a settlement, your weekly benefits will probably not be taxable.

YOU ARE ADVISED TO CONSIDER SEEKING LEGAL, FINANCIAL AND MEDICAL ADVICE BEFORE ENTERING INTO ANY SETTLEMENT.

DESCRIPTION OF BENEFITS

THE DETAILS OF THE BENEFITS AND YOUR RIGHTS AND RESPONSIBILITIES ARE IN THE *STATUTORY ACCIDENT BENEFITS SCHEDULE* OF THE *INSURANCE ACT* (ONTARIO). YOUR INSURANCE COMPANY IS OBLIGATED TO GIVE YOU INFORMATION ABOUT THE BENEFITS AVAILABLE.

The benefits provided under the *Statutory Accident Benefits Schedule* are complex and extensive. A short description of these benefits is provided below.

Weekly Income Benefits
This benefit compensates for lost income if you are unable to perform the essential tasks of the job you did before the accident. You may qualify if you were employed, unemployed but worked 180 days in the twelve months before the accident, on a temporary lay-off or had a contract to start work within one year. The benefit is 80% of your gross income before the accident. The maximum benefit is $600 per week, subject to a minimum weekly amount of $185.60. However, if you are covered by optional weekly income benefits, the maximum benefit may be $750, $900, or $1,050 per week.

Weekly Benefits If No Income
This benefit compensates you if you are unable to perform the essential tasks you normally did before the accident, and do not qualify for a Weekly Income Benefit. The benefit is $185 per week. In addition to this benefit, if you were a primary caregiver for one or more persons in your household, such as a child under age 16 or other person who needs care, you are entitled to a benefit of $50 per week for each person requiring care. If you are covered by optional benefits the additional amount for each person requiring care is $100 per week.

Supplementary Medical and Rehabilitation Benefits
This benefit pays for medical and rehabilitation expenses incurred as a result of your injuries. It also may pay for some other goods and services such as housekeeping and home maintenance. Expenses payable under this section are expenses that are not covered by any other medical plan, such as the Ontario Health Plan, or any medical plans at the workplace.

Maximum Medical and Rehabilitation Benefits
The maximum amount paid for medical and rehabilitation benefits is $500,000. There is a time limit of 10 years, or twenty years less your age on the day of the accident, whichever is longer.

Care Benefits
This benefit compensates for the expense of a professional caregiver or the reasonable expenses incurred in caring for you after the accident.

Maximum Care Benefits
The maximum amount payable per month for care benefits is $3,000. The total maximum amount payable for care benefits is $500,000.

Funeral Expenses
This benefit pays up to $3,000 to cover funeral expenses. If you are covered by optional benefits the maximum amount is $7,500.

Death Benefits
This benefit pays family members of a person killed in an automobile accident. $25,000 is paid to a surviving spouse, $10,000 each to surviving dependants, and $10,000 to a person upon whom the deceased was dependent. The amounts are doubled if you are covered by optional benefits.

Optional Benefits
Optional benefits increase the amount of basic benefits, and must be purchased before the accident. The optional benefits are:

1. Increased Funeral and Death Benefits
2. Increased Weekly Income Benefits
3. Increased Primary Caregiver Benefits

You should consult your insurer and your advisors to determine if you are covered by Optional Benefits.

INSURER'S DISCLOSURE AND ACKNOWLEDGMENT

The insurer acknowledges that it has made available for review by the insured person or the insured person's representative all medical reports, medical records and other information of a medical nature in the insurer's file relating to the insured person.

I certify the information provided in this Notice is complete and correct.

Representative of insurer _____

Telephone number _____

Name of Insurance Company
Ombudsman Liaison Officer* _____

Telephone number _____

*If you have a complaint about your claim, you may contact your insurer's Ombudsman Liaison Officer who will review and attempt to resolve it with you.

Date _____

INSURED'S ACKNOWLEDGMENT

I acknowledge that I have received and read the above Settlement Disclosure Notice provided to me by an insurer, and have considered whether or not to obtain legal, financial and medical advice.

_____ Date _____

Signature of Insured

IF YOU CHANGE YOUR MIND

IF YOU CHANGE YOUR MIND AFTER AGREEING TO SETTLE YOUR CLAIM BY SIGNING A RELEASE, YOU MUST:

NOTIFY THE INSURER IN WRITING AND RETURN ANY SETTLEMENT FUNDS YOU RECEIVED WITHIN 2 BUSINESS DAYS AFTER YOU SIGNED THE RELEASE

IF YOU SIGNED A RELEASE AND LATER SIGNED THIS DISCLOSURE NOTICE, YOU HAVE 2 BUSINESS DAYS FROM WHEN YOU SIGNED THE DISCLOSURE NOTICE IN WHICH TO NOTIFY THE INSURER AND RETURN ANY SETTLEMENT FUNDS YOU RECEIVED.

Form SDN-68 (03/03)

SECTION F – EXPENSE REGULATION

Excerpt from Regulation 664, R.R.O. 1990, made under the *Insurance Act*, as amended to O.Reg. 275/03 (Criteria for Awarding Expenses)..... F - 1

Schedule to Regulation 664, R.R.O. 1990, made under the *Insurance Act*, as amended to O.Reg. 275/03 (Dispute Resolution Expenses)..... F - 1

EXCERPT FROM REGULATION 664, R.R.O. 1990, MADE UNDER THE *INSURANCE ACT*, AS AMENDED TO O.REG. 275/03 (CRITERIA FOR AWARDING EXPENSES)

12. (1) The expenses set out in the Schedule are prescribed for the purpose of subsection 282(11) of the Act.

(2) An arbitrator shall, under subsection 282 (11) of the Act, consider only the following criteria for the purposes of awarding all or part of the expenses incurred in respect of an arbitration proceeding:

1. Each party's degree of success in the outcome of the proceeding.

2. Any written offers to settle made in accordance with subsection (3).

3. Whether novel issues are raised in the proceeding.

4. The conduct of a party or a party's representative that tended to prolong, obstruct or hinder the proceeding, including a failure to comply with undertakings and orders.

5. Whether any aspect of the proceeding was improper, vexatious or unnecessary.

(3) Upon the request of the insurer or the insured person, the arbitrator shall, for the purposes of awarding expenses, take into account all written offers to settle, if any,

(a) that were made after the conclusion of mediation and before the conclusion of the arbitration; and

(b) that were made in accordance with the rules of practice and procedure applicable to the proceeding.

(4) If the arbitrator is requested to take into account a written offer under subsection (3), the arbitrator shall have regard to the terms of the offer, the timing of the offer, the response to the offer and the result of the proceeding.

SCHEDULE

DISPUTE RESOLUTION EXPENSES

(Subsection 282 (11) of the Act)

1. The filing fees paid by the insured person when applying for arbitration may be awarded to the insured person.

2. The filing fees paid by the insured person or the insurer when appealing the order of an arbitrator or applying to vary or revoke an order may be awarded.

3. (1) The legal fees payable by the insured person or the insurer for the following matters may be awarded:

1. For all services performed before an arbitration, appeal, variation or revocation hearing.

2. For the preparation for an arbitration, appeal, variation or revocation hearing.

3. For attendance at an arbitration, appeal, variation or revocation hearing.

4. For services subsequent to an arbitration, appeal, variation or revocation hearing.

(2) The number of hours for which legal fees may be awarded shall be determined by the arbitrator, having regard to the criteria set out in subsection 12 (2) of this Regulation.

(3) The maximum amount that may be awarded for legal fees is the amount calculated using the hourly rates set out in the Dispute Resolution Practice Code published by the Ontario Insurance Commission or Financial Services Commission of Ontario, as it may be amended from time to time.

3.1 (1) The agent's fees payable by the insured person or the insurer for the following matters may be awarded:

1. For the preparation for an arbitration, appeal, variation or revocation hearing.

2. For attendance at an arbitration, appeal, variation or revocation hearing.

3. For services subsequent to an arbitration, appeal, variation or revocation hearing.

(2) The maximum amount that may be awarded for agent's fees is the amount calculated using the hourly rates set out in the Dispute Resolution Practice Code published by the Ontario Insurance Commission or Financial Services Commission of Ontario, as it may be amended from time to time.

4. The amount of the following disbursements made by or on behalf of the insured person or the insurer may be awarded:

1. For long distance telephone, facsimile and other telecommunication charges.

2. For typing, printing and reproducing copies of documents.

3. For the delivery, by mail or courier, of items relating to the arbitration, appeal, variation or revocation hearing.